

Arizona Department of Health Services
Division of Behavioral Health Services
Quality Management Work Plan October 1, 2011 – September 30, 2012

Goal	Strategy	Action Items	Responsible Party	Start Date	End Date
Goal 1. Performance Measures: Contractors will meet the performance standards for the following performance measures: a. Access to Care (ATC) b. Coordination of Care (COC #2) c. Behavioral Health Service Plan (BHSP) d. Behavioral Health Service Provision <u>AHCCCS-owned measures:</u> a. Follow up After Discharge (7 Days) b. Follow up After Discharge (30 Days) c. Treatment of Depression	1.1: ADHS/DBHS to monitor Contractors' compliance with Minimum Performance Standards (MPS) for all performance measures on quarterly basis per AHCCCS Contract as follows: a. ATC: 90% (MPS); 95% (Goal) b. COC: 85% (MPS); 95% (Goal) c. BHSP: 85% (MPS); 95% (Goal) d. Service Provision: 85% (MPS); 95% (Goal) <u>AHCCCS-owned measures:</u> a. F/U after D/C 7 Day: 70% (MPS); 90% (Goal) b. F/U after D/C 30 Day: 80% (MPS); 90% (Goal) c. Depression: TBD (MPS); 90% (Goal)	1.1a:ADHS/DBHS will continue to conduct <i>quarterly performance measure review activities</i> per AHCCCS Contract requirement and as per BQMO Specification Manual FY 2012 as follows: <u>1. Access to Care 23 Day (ATC)</u> <ul style="list-style-type: none"> ADHS/DBHS pulls 90/10 random sample for new enrollments for each GSA (adult and children) from CIS based on adjudicated claims Performance is calculated for each GSA and statewide <u>2. Coordination of Care (COC)</u> <ul style="list-style-type: none"> ADHS/DBHS pulls 90/10 random sample from CIS for each GSA (adult and children) and forwards to RBHAs RBHAs conduct chart reviews for evidence of coordination and returns sample to BQMO, indicating presence or absence of coordination evidence BQMO/IM Team calculates performance for each GSA and statewide <u>3. Behavioral Health Service Plan (BHSP)</u> <ul style="list-style-type: none"> ADHS/DBHS pulls 90%/10% random sample for each GSA (adult and children) and forwards to RBHAs RBHAs forward assessments and treatment plans for each sampled client to BQMO BQMO/OPI review charts to determine status of current assessment and presence of treatment plan reflecting needs defined in the assessment BQMO/IM Team calculates performance based on OPI's reviews tool (attached) for each GSA and statewide <u>4. Behavioral Health Service Provision (BHSPv)</u> <ul style="list-style-type: none"> BQMO/OPI forwards client identifying information of clients who pass on the BHSP measure to ADHS/DBHS/Business Information (BI) along with treatment needs identified on the treatment plans BI pulls encounters for clients in a., above, and matches encounters to service needs identified on the treatment plans 	Office of Performance Improvement	10/01/11	9/30/12

Goal	Strategy	Action Items	Responsible Party	Start Date	End Date
		1.1b. DBHS will conduct data validation activities of Contractor submitted data review (COC#2) at least twice each year.			
	1.2: ADHS/DBHS to provide technical assistance (TA) and/or issue corrective actions if a Contractor fails to meet the MPS for any of the performance measures.	1.2: ADHS/DBHS will provide TA and/or issue corrective actions if a Contractor fails to: <ul style="list-style-type: none"> Meet the MPS for any of the performance measures for two consecutive quarters, and/or Demonstrate statistically significant decline in performance for any of the performance measures for two consecutive quarters DBHS will provide technical assistance to Contractors as needed. 	Office of Performance Improvement	10/01/11	9/30/12
	1.3: ADHS/DBHS to identify barriers and solutions to improve rates of compliance with performance measure at least bi-annually.	1.3: <ul style="list-style-type: none"> DBHS will review statewide data to identify trends and non compliance on quarterly basis If a Contractor fails to meet MPS or demonstrate a significant decline for any of the performance measures for two consecutive quarters DBHS will require conducting a barrier analysis. DBHS will conduct TA as indicated to assist RBHA in barriers identification and implement solutions. DBHS will conduct training sessions with Contractor QM staff related to quarterly statewide trended data as indicated. 	Office of Performance Improvement	10/01/11	9/30/12
Goal 2. Performance Improvement Projects: 1. AHCCCS has waived the requirement for DBHS to submit a self-selected PIP for CYE 2012 2. AHCCCS-DBHS Current Mandated Collaborative PIP: Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services.	ADHS/DBHS to focus resources to collaborate with AHCCCS to ensure Care coordination between acute and behavioral health providers specific to current mandated Collaborative PIP.	<ul style="list-style-type: none"> ADHS will work collaboratively with AHCCCS to facilitate data collection for this PIP ADHS/DBHS will continue to co host meetings between AHCCCS Health Plans and ADHS/DBHS RBHAs for open dialogue regarding data sharing 	Office of Performance Improvement/ PIP Coordinator	10/01/11	9/30/12
Goal 3. Monitoring and Oversight Activities: DBHS and their Contractors will monitor the service delivery system to improve services for behavioral health recipients.	3.1 Ensure Contractor's Annual QM Plan includes sufficient details about the provider monitoring activities	3.1. ADHS/DBHS will : <ul style="list-style-type: none"> Review and approve Contractor Annual QM Plans Evaluate the activities related provider monitoring Provide T/A to Contractors with insufficient provider monitoring plans as needed. 	Office of Performance Improvement	10/01/11	9/30/12

Goal	Strategy	Action Items	Responsible Party	Start Date	End Date
	3.2 Ensure Contractors' ongoing adherence to the provider monitoring plan.	3.2. ADHS/DBHS will: <ul style="list-style-type: none"> • Conduct data validation activities during which Contractor's provider monitoring activities will be reviewed (Calendar of site visits, TA provided, CAP issued and Follow up on CAP etc) • Will require a CAP or issue a warning if a Contractor found non compliant with its provider monitoring plan. • DBHS will present data validation results in QM committee meetings. 	Office of Performance Improvement	10/01/11	9/30/12
	3.3: Ensure Contactor compliance with Quality of Care review requirements in accordance with ADHS/DBHS QOC Policy (QM 2.7) and AMPM 960.	3.3: ADHS/DBHS will: <ul style="list-style-type: none"> • Monitor all Incident, Accident, and Death Reports received from each RBHA to: <ul style="list-style-type: none"> ○ Investigate all unknown deaths, accidental deaths, and suicide deaths. ○ Investigate all questionable incidents and accidents reported by RBHA's as outlined in ADHS/DBHS QOC Policy QM 2.7. • Conduct Inter Rater Reliability test among all QOC team staff on weekly basis to ensure consistency in review findings and recommendations • Monitor each RBHA's tracking and trending of QOC concerns and QOC corrective action plans during semi-annual data validation audits. • Provide oversight of each RBHA's QOC policy, QOC process, during annual administrative reviews. • Evaluate and investigate all incidents, accidents and deaths which are referred to ADHS/DBHS from outside referral agencies and stakeholders. 	Office of Performance Improvement	10/01/11	9/30/12
	3.4: Ensure Contractor compliance with Peer Review requirements.	3.4: During Data Validation site visits and ADHS Annual Admin Review, ADHS/DBHS will monitor: <ul style="list-style-type: none"> • Peer Review policy and protocol to ensure compliance with ADHS and AHCCCS requirements • Peer Review Committee process, meeting minutes and agenda to ensure there is no breach in confidentiality. 	Office of Performance Improvement	10/01/11	9/30/12
	3.5: Ensure Contractor compliance with all delegated QM Activities at least annually.	3.5: ADHS/DBHS will: <ul style="list-style-type: none"> • Conduct an Annual Administrative Review of each Contractor to assess compliance with delegated activities. 	Office of Performance Improvement	10/01/11	9/30/12

Goal	Strategy	Action Items	Responsible Party	Start Date	End Date
		<ul style="list-style-type: none"> Conduct focused reviews and/or ad hoc data validation activities of Contractors as indicated by trended data 			
4. Outcomes Reporting: DBHS will monitor and report system wide prioritized outcomes for recipients receiving behavioral health services.	4.1: DBHS will ensure timely reporting of Outcome Measures for the ADHS/DBHS Outcome Framework/ Dashboard.	4.1. ADHS/DBHS/BQMO will: <ul style="list-style-type: none"> Collect outcome framework data quarterly and annually Conduct analysis of data Regularly update <i>At a Glance</i> reports for use in the outcome dashboard Report findings quarterly and annually in ADHS/DBHS Leadership Team Regularly update Outcome Framework at ADHS/DBHS website for external partner, stakeholder and Consumers 	BQMO/ Business Information	10/01/11	9/30/12
	4.2: DBHS will present statewide outcome data in the QM Committee meetings at least biannually.	4.2: At a Glance Data DBHS will be presented semi annually in the: <ul style="list-style-type: none"> QM Committee Children's QM subcommittee ADHS/DBHS Leadership Team 	BQMO/ Business Information	10/01/11	9/30/12
5. Reporting Requirements: DBHS will submit timely, logical and accurate QM deliverables to AHCCCS per the AHCCCS contract.	5.1 Ensure all QM deliverables are accurate and submitted timely.	5.1a. DBHS QM will conduct quality checks of all data provided in deliverables to AHCCCS before submission.	Office of Performance Improvement	10/01/11	9/30/12
		5.1b. DBHS QM will receive approval for AHCCCS deliverables from ADHS/DBHS Leadership Team prior to submission to AHCCCS.	Office of Performance Improvement	10/01/11	9/30/12
	5.2 Ensure Contractor deliverables are accurate and submitted timely.	5.2a. DBHS will evaluate Contractor timely submission of quarterly and annual deliverables	Office of Performance Improvement	10/01/11	9/30/12
		5.2b. DBHS will conduct data validation activities on Contractor submitted data semi annually.	Office of Performance Improvement	10/01/11	9/30/12
		5.2c. DBHS QM will require a CAP or other performance improvement activity from any Contractor not meeting DBHS deliverables requirements.	Office of Performance Improvement/QM Committee	10/01/11	9/30/12

**Arizona Department of Health Services
Division of Behavioral Health Services**



**2012 Annual Medical Management/Utilization Management Plan
(AHCCCS Contract Year October 1, 2011 – September 30, 2012)**

**Alexandra M. O'Hannon, Medical Management Office Chief
Bureau of Quality Management Operations**

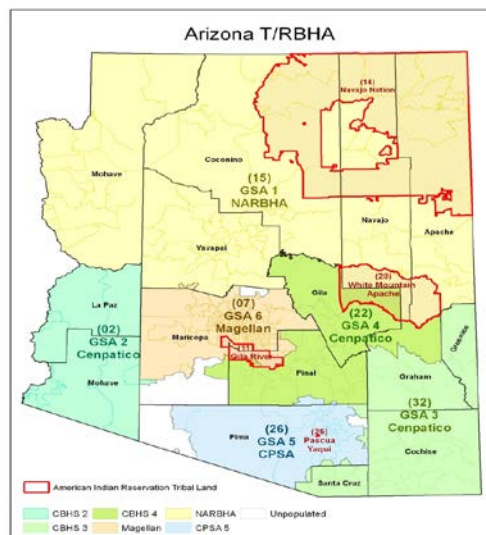
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Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) serves as the single state authority to provide administration, regulation, and monitoring of all facets of the State public behavioral health system. ADHS/DBHS contracts with community-based organizations known as Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TBHAs) to administer behavioral health services throughout the State. ADHS/DBHS Contractors function in a fashion similar to a health plans and are responsible for the development of service networks for adult and child behavioral health recipients.

The state is divided into six geographical service areas (GSAs) served by four Contractors:



- [Cenpatico Behavioral Health of Arizona](#) (CBHAZ) serves three GSAs (GSAs 2, 3 and 4) covering Pinal, Gila, Yuma, La Paz, Graham, Greenlee, Santa Cruz and Cochise Counties.
- [Community Partnership of Southern Arizona](#) (CPSA) serves one GSA (GSA5) covering Pima County.
- [Northern Arizona Behavioral Health Authority](#) (NARBHA) serves one GSA (GSA 1) covering Mohave, Coconino, Apache, Navajo, and Yavapai Counties.
- [Magellan of Arizona](#) (Magellan) of Arizona serves one GSA (GSA 6) covering Maricopa County.

ADHS/DBHS has Intergovernmental Agreements (IGAs) with three of Arizona's American Indian Tribes to deliver behavioral health services to persons living on the reservations:

- [Gila River Indian Community](#)
- [Pascua Yaqui Tribe](#)
- [White Mountain Apache Tribe of Arizona](#)

The ADHS/DBHS Medical/Utilization Management (MM/UM) program is designed to assure systemic, appropriate utilization of services to achieve desired outcomes by establishing utilization management requirements, monitoring utilization data, and promoting the use of nationally recognized best practices through practice guidelines and approved use of new technologies. All ADHS/DBHS MM/UM program requirements are either directly reflected in the contracts with ADHS/DBHS Contractors, or are in policies that are incorporated into the contracts by reference. ADHS/DBHS Contractors must implement and adhere to ADHS/DBHS' requirements and must describe these practices in the Contractors' annual MM/UM Plans. Oversight of Contractors adherence to these practices is accomplished through the review of Contractor monthly and quarterly submissions of utilization data, ADHS/DBHS data validation exercises and the Annual Administrative Review process.

Vision

ADHS/DBHS maintains a vision for the delivery of behavioral health services that provides the basis for all MM/UM activities. The ADHS/DBHS vision states:

All Arizona residents touched by the public behavioral health delivery system are easily able to access high quality prevention, support, rehabilitation and treatment services that have resiliency and recovery principles at their core, which assist them in achieving their unique goals for a desired quality of life in their homes and communities.

To support the ADHS/DBHS vision, the goals of the ADHS/DBHS Medical/Utilization Management Program are to:

- Monitor utilization of behavioral health services.
- Provide oversight of delegated functions.
- Provide oversight of Contractor medical/utilization management processes.
- Provide authorization services for TBHA Contractors.
- Coordinate the Pre-Admission Screening and Resident Reviews (PASRR) for individuals in need of placement in skilled nursing facilities.
- Implement nationally recognized best practices in the area of care coordination.
- Validate utilization data.
- Ensure that Notice of Action requirements are adhered to.

Activities defined to support MM/UM processes and program goals are delineated in the 2012 ADHS/DBHS MM/UM Work Plan (Attachment C). These activities serve to direct the ADHS/DBHS MM/UM program and include clearly defined goals, measurable objectives, data feeds, responsible parties, frequency of activities and target dates for activities completion. ADHS/DBHS MM/UM activities include Contractor, stakeholder and recipient input and serve to further the vision of ADHS/DBHS.

The ADHS/DBHS MM/UM Plan includes activities designed to meet federal and AHCCCS requirements and all data driven, focused performance improvement activities conducted by ADHS/DBHS Contractors. ADHS/DBHS provides oversight and technical

assistance to every Contractor to ensure compliance with all performance standards and contractual requirements.

I. Medical/Utilization Management Administrative Oversight

(AMPM Chapter 1000, Policy 1010, Contract ¶ 21)

ADHS/DBHS implements its MM/UM plan both internally and through its contracts with T/RBHAs. For example:

- Tribal Prior Authorizations, Concurrent and Retrospective Reviews are conducted by ADHS/DBHS Medical Management Staff in accordance with AHCCCS requirements
- Review and Analyze utilization data provided by RBHAs on monthly and quarterly basis, which includes
 - Readmits and Length of Stay (LOS)
 - Court Ordered Treatment
 - SMI Eligibility Determination
 - Authorizations which is a part of the *Monthly Enrollee Grievance Report* submitted to AHCCCS
- ADHS/DBHS Conducts monthly MM/UM Committee meetings where all components of the MM/UM Plan/Program are discussed evaluated and approved.
- MM/UM Committee reports directly to the Leadership team for recommendations and approval
- ADHS/DBHS implement two subcommittees:
 - Pharmacy and Therapeutic Committee where drug and medication utilization and related issues are presented and discussed
 - T/RBHA MM/UM Coordinators meetings serves as a venue for its Contractor MM/UM program oversight and as a means for ongoing technical assistance.
- ADHS/DBHS conducts onsite data validation visits on a biannual basis
- ADHS/DBHS Conducts Annual Administrative Reviews of its contractors
- ADHS/DBHS reviews and approves new Technologies and new use of existing technologies

Additionally, ADHS/DBHS delegates the following MM/UM functions to its Contractors:

- RBHAs Prior Authorization, Concurrent Review, and Retrospective Review, Inter-rater reliability
- Care Coordination/Case Management
- Provider and Recipient over and under utilization monitoring and action
- Pharmacy utilization review at provider and recipient level

ADHS/DBHS provides oversight and has ultimate accountability for all functions delegated to its Contractors ([Please review Section III-Delegated Activities](#))

Structural Framework and Communications

The ADHS/DBHS Office of Medical Management/Utilization Management (MM/UM) operates within the Bureau of Quality Management Operations (BQMO). The BQMO works collaboratively with all functional areas of ADHS/DBHS to evaluate service utilization throughout Arizona. MM/UM administrative oversight and communication activities are conducted via ADHS/DBHS committees and data sharing. ADHS/DBHS committees are utilized as a forum for decision making, performance monitoring, development and guidance of performance improvement activities, and as a means for incorporating stakeholder and member feedback into MM/UM activities.

ADHS/DBHS Leadership Team

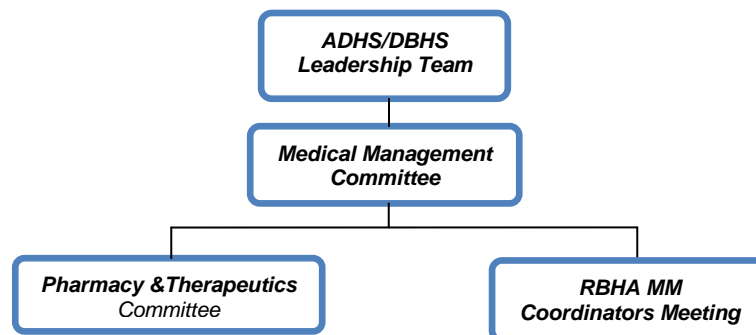
The ADHS/DBHS Leadership Team (SET) acts as the governing, policy making body for ADHS/DBHS, providing strategic direction and ultimate authority for the scope of BQMO activities. The Leadership Team ensures ongoing communication between BQMO and other functional areas in the division of behavioral health service for service alignment. The Leadership Team acts as the final approval authority for all activities related to the ADHS/DBHS system of care.

Membership: ADHS/DBHS Leadership Team

- Laura Nelson, MD, Deputy Director
- Steven Dingle, MD, Chief Medical Officer
- Sara Salek, MD, Deputy Chief Medical Officer
- Robert Sorce, Assistant Director
- Ann Froio, Assistant Director
- Cynthia Lane, Branch Chief, Finance
- Margery Ault, Branch Chief, Consumer Rights
- Claudia Sloan, Special Project Administrator

Meeting Frequency: Weekly

MEDICAL MANAGEMENT COMMITTEE STRUCTURE



MM/UM Committee

The ADHS/DBHS MM/UM Committee operates under the direction of ADHS/DBHS' Leadership Team. The Chief Medical Officer chairs the committee; is responsible for the implementation of the MM/UM Plan; and has substantial involvement in the assessment and improvement of MM/UM activities. Committee members are informed of confidentiality and conflict of interest requirements related to serving on the committee. Sign-in sheets with confidentiality and conflict of interest language are completed at all meetings.

The MM/UM Committee analyzes MM/UM reports to identify potential opportunities to improve availability, access, and delivery of behavioral health services. This Committee is responsible for developing solutions to issues identified in MM/UM reports. MM/UM program objectives, policies, and procedures are reviewed (at a minimum) annually and modified or updated as needed. The MM/UM Committee addresses and makes recommendations to the ADHS/DBHS Leadership Team concerning the following utilization functions:

- Monitoring of over and under-utilization of care services at both the provider and recipient level;
- Validating utilization data provided by its Contractors to ensure accuracy;
- Assessment of the utilization management program and develop/adopt utilization criteria;
- Development and adoption of clinical practice guidelines that are based on scientific evidence. These guidelines are reviewed and updated at least annually;
- Monitoring Contractors' coordination of care;
- Review of the application of new technologies, as well as new uses of existing technologies; and,
- Monitor and support Contractors' UM activities including utilization practice patterns, Notices of Actions, policies and procedures to ensure contract compliance.

The annual MM/UM Plan and the annual MM/UM Evaluation as well as recommendations for MM/UM activities are reviewed and approved by this Committee prior to presentation to the ADHS/DBHS Leadership Team.

Membership:

MM/UM Committee Membership (Voting Members)

- Steven Dingle, MD, Chief Medical Officer (**Chair**)
- Alexandra O'Hannon, Office Chief, Medical Management (**Co-Chair**)
- Sara Salek, MD, Deputy Chief Medical Officer
- Ashraf Lasee, Branch Chief, BQMO
- Laura Nelson, MD, Deputy Director and Chief Medical Officer
- Cynthia Lane, Division Financial Officer
- Margery Ault, Branch Chief, Consumer Rights
- Melissa Thomas, Acting Branch Chief, Program Operations
- Ann Froio, Assistant Director

Meeting Frequency: Monthly

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P and T) Committee provides guidance to ADHS/DBHS Contractors regarding formulary decisions; safe and effective prescribing; reviews of new technologies or requests for new use of existing technologies; and monitoring of psychiatric medications.

All Subcommittee members are informed of confidentiality and conflict of interest requirements related to serving on the committee. Sign-in sheets with confidentiality and conflict of interest language are completed at all meetings. The subcommittee chair reports on utilization of psychiatric medication and formulary recommendations at the MM/UM Committee.

Membership:

Pharmacy and Therapeutics Committee Membership

- Steven Dingle, MD, Chief Medical Officer (**Chair**)
- Alexandra O'Hannon, Office Chief, Medical Management (**Co-Chair**)
- Sara Salek, MD, Deputy Chief Medical Officer
- Margaret McLaughlin Acting Branch Chief, Contract Compliance
- Cynthia Lane, Division Financial Officer
- Suzanne McClelland, Arizona State Hospital Pharmacist
- Shannon Shiver, Utilization Specialist
- Earlene Allen, Health Program Manager
- Karla Schaff, Utilization Specialist

Meeting Frequency: Quarterly, or as needed

MM/UM Coordinators Meeting

The ADHS/DBHS Contractor MM/UM Coordinators Meeting serves as a venue for ADHS/DBHS Contractor MM/UM program oversight and as a means for ongoing technical assistance to ADHS/DBHS Contractors. MM/UM Coordinator Meeting summaries are provided to the ADHS/DBHS MM/UM Committee at least quarterly.

MM/UM Coordinators Meeting Membership:

- Alexandra O'Hannon, Office Chief, Medical Management (**Chair**)
- Ashraf Lasee, Branch Chief of Quality Management Operations
- Steven Dingle, MD, Chief Medical Officer
- Contractor MM/UM Representatives
- MM/UM Staff

Meeting Frequency: Quarterly, or as needed

MM/UM Program Staff

The ADHS/DBHS Office of MM/UM is staffed with individuals who have the knowledge, training and experience to perform the MM/UM functions and responsibilities in a timely and knowledgeable manner as required by ADHS/DBHS'

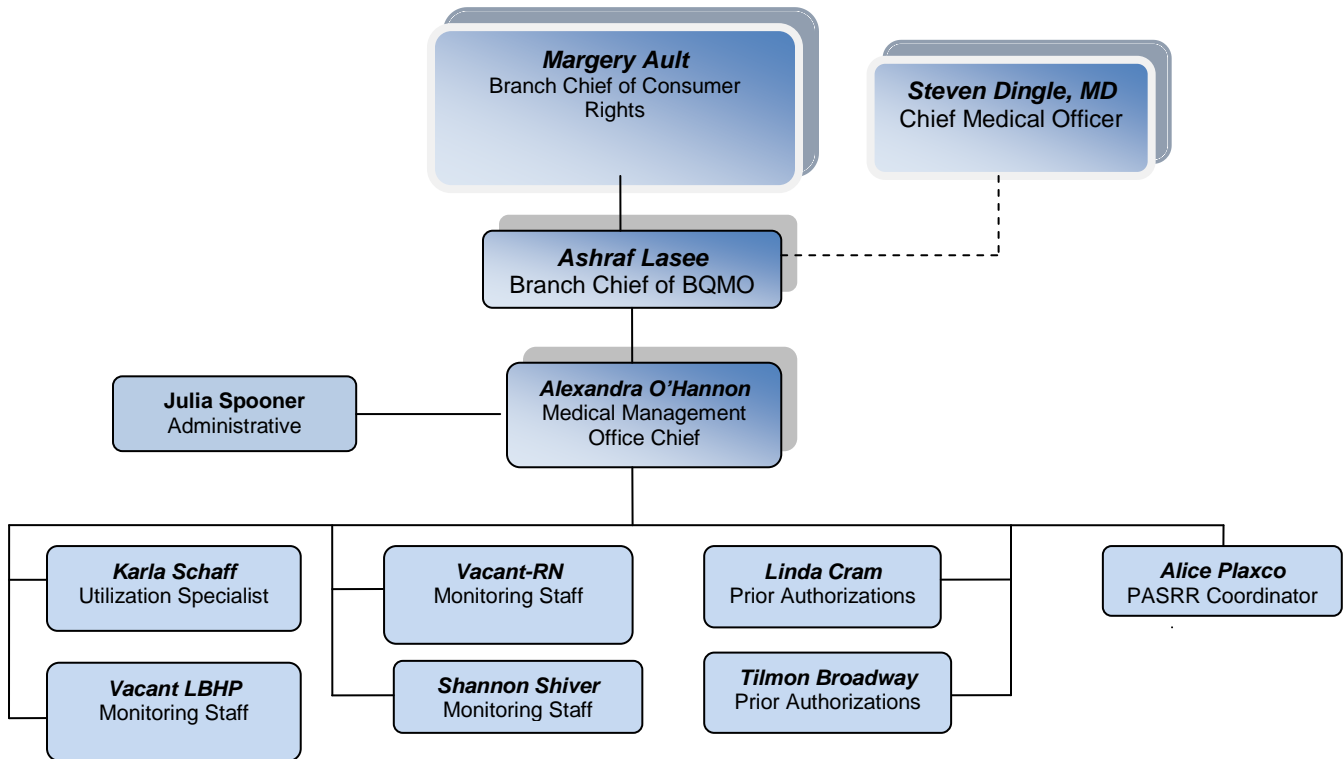
contract with AHCCCS. The Office of MM/UM consists of nine (9) positions: a Chief Medical Officer, a Medical Management Office Chief, two (2) Prior Authorizations Coordinators, one (1) Pre-Admission, Screening and Resident Review (PASRR) Coordinator, one (1) Utilization Specialist, two (2) Monitoring Specialist (one Monitoring Specialist position is currently vacant), and one (1) Administrative Assistant. As depicted in the flow chart below, the Office of MM/UM within the BQMO is overseen by the Branch Chief of the Office of Consumer Rights. Responsibilities are outlined as table below.

Staff	Responsibilities
Steven Dingle, MD <i>Chief Medical Officer</i>	<p>The Chief Medical Officer will:</p> <ul style="list-style-type: none"> • Chair MM/UM Committee Meeting • Provide Consultation on all clinical aspects of the program (Denial, NOA etc) • Work with RBHAs Chief Medical Officers on issues related to drug utilization, new medical technologies, practice protocols etc • Member of the ADHS/DBHS Leadership Team
Margery Ault, JD <i>Branch Chief of the Consumer Rights</i>	<ul style="list-style-type: none"> • Supervises the Branch Chief for BQMO • Provides administrative, executive-level leadership, guidance and support for BQMO • Member of ADHS/DBHS Leadership Team
Ashraf Lasee, MBBS, MPH, Dr. PH <i>Branch Chief of the Bureau of Quality Management Operations</i>	<ul style="list-style-type: none"> • The Branch Chief for the Bureau of Quality Management Operation is responsible to ensure ongoing communication and collaboration between Executive Leadership, BQMO, and other functional areas of the Division of Behavioral Health Services. • Provides administrative support and technical assistance to three Offices in the Bureau: Office of MM/UM, Office of Performance Improvement and the Office of Information Management. • Leadership role to communicate program related issues and needs with AHCCCS and ADHS/DBHS Leadership Team.
Alexandra O'Hannon MSW, CPHQ <i>Medical Management Office Chief</i>	<p>MM/UM Office Chief provides oversight of:</p> <ul style="list-style-type: none"> • All components of the PASRR process • All components of the Tribal Prior Authorization Process • Oversight and facilitation of the Administrative Review Process • The MM/UM component of the Operational and Financial Review process • Six (6) staff • Oversight and facilitation of data validation activities • Writes policies and procedures for both internal and external use • Designs databases to effectively track service utilization

Staff	Responsibilities
	<ul style="list-style-type: none"> • Reviews documentation specific to children placed in out of state placements • Provides technical assistance to internal and external customers • Participant in the MM/UM, QM, Children's QM, and Pharmacy and Therapeutics Committee • Monitors Contractors' utilization practices • Monitors Contractors' compliance with the ADHS/DBHS contract, AMPM, and the Federal Regulations
Shannon Shiver MA <i>Utilization Specialist</i>	<ul style="list-style-type: none"> • Provides transition oversight for recipients in the Arizona State Hospital • Acts as the Health Plan Liaison • Conducts data analysis and data validation • Provides RBHA UM/MM Program oversight • Tracks and monitors children placed in out of state placements • Conducts Administrative Reviews of the RBHAs • Evaluates and monitors Contractors' corrective action plans • Participates in various committees • Conducts Research Activities • Participates in the AHCCCS Operation and Financial Review process • Provides technical assistance to internal and external customers • Represents ADHS/DBHS in various capacities
Karla Schaff MPH <i>Utilization Specialist</i>	<ul style="list-style-type: none"> • Provides RBHA UM/MM Program oversight • Conducts data analysis and data validation • Conducts Administrative Reviews of the RBHAs • Participates in various committees • Conducts Research Activities • Participates in the AHCCCS Operation and Financial Review process • Provides technical assistance to internal and external customers • Provides oversight of the RBHAs' MCE studies • Represents ADHS/DBHS in various capacities
Vacant Position- RN <i>Monitoring and Oversight</i> (Position advertized)	<p>The following will be the responsibility of the newly hired staff:</p> <ul style="list-style-type: none"> • Gather, plan, organize and evaluate information from multiple data sources • Conduct case file reviews and audits, • Conduct Administrative Reviews • Conduct research • Conduct data validation • Evaluate clinical decision- making specific to Notices of

Staff	Responsibilities
	<p>Actions</p> <ul style="list-style-type: none"> • Participate in the Peer Review Process • Synthesize data • Produce Reports used for decision-making
<p>Vacant Position-LBHP <i>Monitoring and Oversight</i> (Position advertized)</p>	<p>The following will be the responsibility of the newly hired staff</p> <ul style="list-style-type: none"> • Gather, plan, organize and evaluate information from multiple data sources • Conduct case file reviews and audits, • Conduct Administrative Reviews • Conduct research • Conduct data validation • Evaluate clinical decision- making specific to Notices of Actions • Participate in the Peer Review Process • Synthesize data • Produce Reports used for decision-making
<p>Tilmon Broadway BS <i>PA Coordinator</i></p>	<ul style="list-style-type: none"> • Collects, reviews, and authorizes RTC, L2 Group Home, and Hospital services for Tribal recipients • Conducts retrospective reviews • Participates in Inter-rater reliability testing • Manages various internal databases • Runs reports for the BQMO • Participates in the MM/UM Committee • Participates in meetings with internal and external stakeholders
<p>Alice Plaxco <i>PASRR Coordinator</i></p>	<ul style="list-style-type: none"> • Manages the Pre-Admissions Screening and Resident Review process for Arizona's non- DDD residents • Provides reports to AHCCCS • Participates in the Operational and Financial Review • Coordinates with the ADHS/DBHS Chief Medical Officer and Medical Director
<p>Linda Cram BSW <i>PA Coordinator</i></p>	<ul style="list-style-type: none"> • Collects, reviews, and authorizes RTC, L2 Group Home, and Hospital services for Tribal recipients • Conducts retrospective reviews • Participates in Inter-rater reliability testing • Runs reports for the BQMO and the tribes • Participates in the MM/UM Committee • Participates in meetings with internal and external • In the absence of Ms. Plaxco, acts as the backup PASRR Coordinator.
<p>Julia Spooner <i>Administrative Assistant</i></p>	<ul style="list-style-type: none"> • Administratively supports the Office of Medical Management • Takes minutes for meetings • Manages internal and external communications

ORGANIZATION STRUCTURE OFFICE OF MEDICAL MANAGEMENT



II. Monitoring and Evaluation of Service Delivery

(AMPM Chapter 1000, Policy 1020, Policy 1020, ADHS/DBHS Contract ¶ 21)

The ADHS/DBHS MM/UM Plan identifies all monitoring and evaluation activities conducted by the ADHS/DBHS Office of MM/UM, including the monitoring and oversight of Contractor MM/UM activities. New initiatives and performance improvement activities are implemented via analysis of data and evaluation of systems performance. Initiatives are evidenced based and inclusive of feedback from behavioral health recipients and stakeholders.

Annual Evaluation

As part of its MM/UM program, ADHS/DBHS conducts biannual evaluations of the MM/UM Work Plan within the MM/UM Committee. The biannual evaluations assist in identifying trends and assessing where additional focus may be warranted. These evaluations are also used to determine the scope of the coming year's activities and in the development of MM/UM processes and performance measures. The evaluation identifies:

- Goals and tasks completion status
- Data trends
- Changes to the scope of the work plan
- Goals and tasks timelines
- Corrective actions

Data Integrity

Accurate and reliable data is imperative for the success of the ADHS/DBHS MM/UM program. Per [Provider Manual Section 7.5, Enrollment, Disenrollment and Other Data Submissions](#), Contractors must maintain a health information system which includes data elements such as member demographics, service utilization, provider characteristics, enrollment, outcomes measures and diagnoses for use in ADHS/DBHS and Contractor MM/UM activities. Demographic data submitted to the ADHS/DBHS Client Information System (CIS) must pass a series of validation measures and logic safeguards prior to acceptance. Each validation measure or edit is designed to operate in a specific manner to ensure accuracy, completeness and logic. ADHS/DBHS provides direction related to systems edits and business rules to its Contractors through the [Demographic and Outcome Data Set Users Guide](#) (DUG).

The Office of Program Support publishes the [Program Support Procedures Manual](#), which outlines provisions for daily, weekly, and monthly claims and encounters processing. This manual includes operations details and a description of the interface between Contractors, ADHS/DBHS, and AHCCCS along with a description of monitoring processes undertaken by ADHS/DBHS. Monitoring includes data validation in conjunction with fraud and abuse reviews. Training and technical assistance is provided to Contractors as needed. In addition to ensure accuracy and completeness of service utilization data, ADHS/DBHS requires Contractors to conduct validation studies as outlined in ADHS/DBHS [Provider Manual, Section 8.1 Encounter Validation Studies](#).

The BQMO Specifications Manual includes details on the ADHS/DBHS methodologies for calculating, reporting, and analyzing all performance indicators. When submitting data to ADHS/DBHS, Contractors are required to utilize standardized data collection tools. The standardization of reporting ensures critical data elements are provided consistently across Contractors for improved analysis on a statewide level. ADHS/DBHS mandates that no Contractor exceed an allowable error rate of 5 percent in any data submission for more than two quarters. Any Contractor exceeding the allowable error rate on MM/UM data submissions are subject to corrective actions, sanctions, and other contractual remedies.

For Tribal utilization data (which is mainly authorization data), ADHS/DBHS utilizes an Access database to monitor and track authorization patterns every other month. This information is shared with Tribal Regional Authorities so they are aware of the status of prior authorization, concurrent and retrospective reviews and to ensure that the times are met in making medical necessity determination. However, ADHS/DBHS has not used Tribal utilization (authorization) data to detect utilization patterns in terms of over and under utilization of services. TRBHAs are not required to submit flat files for utilization

data (COT, SMI Eligibility determination, LOS and Readmissions) like the RBHAs are, therefore, ADHS/DBHS is not able to conduct utilization analysis for this population.

Data Validation:

The Office of MM/UM conducts data validation activities on the following Contractor data submissions:

- Prior Authorization
- Length of Stay/Readmissions
- SMI Determination,
- Court Ordered Treatment

Data validation activities occur twice per year and support the integrity of data reported to ADHS/DBHS. Negative trends identified over multiple reporting periods for any one Contractor may result in an ad hoc focused review conducted at the Division's discretion, and/or Corrective Action or Sanction.

ADHS/DBHS Annual Administrative Review

ADHS/DBHS conducts comprehensive administrative review of its contractors (RBHAs and TBHAs) to evaluate the performance of Contractors' MM/UM Program/Plan, and the ADHS/DBHS delegated functions. Results are shared with Contractors and actions are taken based on performance.

Confidentiality

Contractors must adhere to the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules when working with recipient data or engaging in discussions regarding recipient specific information. ADHS/DBHS [Provider Manual, Section 4.1, Disclosure of Behavioral Health Information](#) and ADHS/DBHS [Policy and Procedure Manual, Section CO 1.4 Confidentiality](#) provide additional guidance on requirements for use and disclosure of behavioral health recipient information.

Under and Over Utilization

Contractors must evaluate the over and under utilization of services from an individual member and systemic perspective in order to identify members who require additional assistance and opportunities to address the quality of care provided and/or capacity enhancement. ADHS/DBHS monitors its Contractors' processes for adhering to the Over and Under Utilization policy and identifying under and over utilization of services through the collection of several data points in standardized quarterly MM/UM reports. The MM/UM Committee is charged with reviewing these reports for systemic trends; implementing/approving improvement actions when necessary and assessing actions for effectiveness. ADHS/DBHS collects Contractor Levels 1-4 Readmission Rate and Length of Stay data; prior authorizations/notices of action logs; Court Ordered Treatment (COT) and Seriously Mentally Ill (SMI) eligibility determination rates for use in systems evaluation. ADHS/DBHS monitors Contractors' compliance with this requirement through assessment and approval of the Contractor MM/UM Plans and via the Annual Administrative Review.

Pharmacy Utilization Review

ADHS/DBHS monitors utilization of psychotropic medication through the standardized Quarterly Pharmacy Utilization Report. Pharmacy utilization trends are reviewed and analyzed on a quarterly basis and then are presented to the P and T Committee to discuss patterns of utilization. Performance improvement activities are implemented as necessary and monitored by the committee. ADHS/DBHS monitors its Contractors pharmacy utilization practices, including the use of new technologies or new use for existing technologies, through quarterly data submissions, the Annual Administrative Review, and through the Contractors processes for prior authorization of non-formulary drug requests.

Evaluation of New Technologies and New Uses of Existing Technologies

There are few new technologies or new uses for existing technology in the mental health field; still, the P and T Committee also serves as a formal venue to discuss psychiatric procedures, new medications and treatment modalities, consideration of new uses for existing technology, and medication utilization. Should a Contractor want to administer a new medication or use an existing technology for a newly identified purpose, the Contractor must first submit a report to ADHS/DBHS explaining the Contractor's rationale for making such a request. The report must include (at a minimum) a literature based, in-depth analysis of the medication/technology requested, a cost analysis, and a benefit analysis. Once submitted to the Medical Director, the request is brought to the P and T Committee for consideration. The P and T Committee is scheduled to meet on a quarterly basis; however, should a request for a new technology or new use of an existing technology occur, the P and T Committee is prepared to meet on an ad hoc basis to ensure that Contractors and Recipients receive a response in a timely manner. New technologies are implemented via additions to the ADHS/DBHS [Provider Manual, Section 3.16 Medication Formulary](#). Medical policies are created when necessary and follow a detailed process that includes distribution for public comment and approval by AHCCCS prior to implementation.

[Tribal Prior Authorization, Concurrent Review and Retrospective Review](#)

[Tribal Authorizations \(Prior Auth, Concurrent Review, Retrospective Reviews\)](#) are conducted by the ADHS/DBHS prior authorization specialists. Two full time staff are dedicated for completing the TBHA's prior authorizations, concurrent review, and retrospective review functions for Level I (Hospitalization and RTC) and Level II group homes. Staff uses medical necessity coverage criteria based on nationally recognized, evidence based practices approved by the ADHS/DBHS Medical Directors in consultation with T/RBHA Medical Directors. Requests to authorize services for Tribal Recipients are communicated to ADHS/DBHS telephonically, electronically, and/or via fax Monday thru Friday from 8:00 am to 5:00 pm. ADHS/DBHS provides e-mail notification to the TBHA case managers once the requested service has been authorized. The criteria used to determine medical necessity for ADHS/DBHS Tribal Recipients is the same criteria used by the RBHAs. The admission and ongoing stay criteria for Acute Hospitalizations, Level I Residential Treatment Centers, and Level II Behavioral Health Group Homes are as follows:

Admission to Psychiatric Acute Hospital or Sub-Acute Facility Authorization
Criteria

A person must meet ALL criteria in Sections A., C., and D., and at least ONE of the criteria in Section B. for admission to a psychiatric acute hospital or sub-acute facility.

A. DIAGNOSIS

A specific diagnosis is not a condition for admission to an inpatient setting; however a specified diagnosis within the range of 290 through 316.99 is required to be documented at the time of discharge from inpatient services.

B. BEHAVIOR AND FUNCTIONING

1. Imminent risk of danger to self or others as a result of a behavioral health condition as evidenced by:
 - a. Current suicidal ideation, behavior or intent,
 - b. Current homicidal or significant assaultive ideation, behavior or intent, or
 - c. Immediate physiologic jeopardy.
2. Disturbance of mood, thought or behavior which renders the person acutely incapable of developmentally appropriate self-care or self- regulation;
3. Disturbance of mood, thought or behavior that requires an assessment or medication trial that cannot be safely or adequately implemented in a less restrictive setting; or
4. Level of functioning that does not meet the above criteria, but less restrictive levels of care suitable to the behavioral health needs of the person are unavailable, or the person cannot return to his or her residence due to risk of harm to self or others due to a treatable behavioral health disorder, or there is a likelihood of imminent behavioral health decompensation.

C. INTENSITY OF SERVICE

This type of service provides planned, comprehensive assessment or treatment involving close daily psychiatric supervision and 24 hour medical supervision. Treatment should be in the least restrictive type of service consistent with the person's need and therefore should not be instituted unless there is documentation of a failure to respond to or professional judgment of an inability to be safely managed in a less restrictive type of service.

D. EXPECTED RESPONSE

1. The client's behaviors and symptoms, which were identified as reasons for admission, can be effectively treated by medically indicated treatment available in this setting.

2. The treatment can reasonably be expected to improve or stabilize the patient's condition so that this type of service will no longer be needed.

Level I Inpatient Treatment Continued Authorization Criteria

A person must meet ALL criteria in Sections A and E, at least ONE of the criteria in each of Sections B, C and must meet Section D for continued stay in a psychiatric acute hospital or sub acute facility.

A. DIAGNOSIS

A specified diagnosis within the range of 290 through 316.99 is required to be documented at the time of discharge from inpatient services.

B. BEHAVIOR AND FUNCTIONING

1. Emergence or continued evidence of symptoms which reflect imminent risk of danger to self or others as a result of a behavioral health condition, as evidenced by:
 - a. Current suicidal ideation, behavior or intent, or
 - b. Current homicidal or significant assaultive ideation, behavior or intent, or
 - c. Ongoing physiologic jeopardy; or
2. Continued disturbance of mood, thought or behavior which renders the person acutely incapable of developmentally appropriate self-care or self-regulation; or
3. Significant regression of the person's condition is anticipated without continuity of this type of service.

C. INTENSITY OF SERVICE

There is documented evidence that the person requires at least one of the following:

1. Continued planned, comprehensive assessment or treatment involving close daily psychiatric supervision and 24 hour medical supervision. This may be as a result of a change in diagnosis, treatment failure, or newly-discovered aspect of the person's case necessitating a significant change in the treatment plan; or
2. Close, continuous, 24 hour skilled medical/nursing supervision of the person's behaviors, which are due to a behavioral health condition, in order to prevent injury to the person or others; or
3. Pharmacotherapy which requires continuous, skilled medical/nursing supervision for safe, effective use; or
4. Skilled nursing observation and care in the management of disturbances of mood, thought or behavior which cannot be provided by non-medical personnel; or
5. Repeated use of physical restraint; or

6. Psychiatric acute hospital or sub-acute facility services may be continued if the person no longer requires the type of service provided in a psychiatric acute hospital or sub acute facility but there is not an available lower intensity of services suitable to the behavioral health needs of the person or the person cannot return to the person's residence because of a risk to harm self or others.

D. EXPECTED RESPONSE

There is documented evidence that:

1. Active treatment is provided that is reducing the severity of disturbances of mood, thought or behavior which were identified as reasons for admission; or
2. There has been a re-evaluation and subsequent change in the treatment plan.
AND
3. There is still an expectation that continued treatment in this type of service can reasonably be expected to improve or stabilize the patient's condition so that this type of service will no longer be needed. OR
4. There is no less restrictive type of service available to safely meet the person's behavioral health needs.

E. DISCHARGE PLAN

There is a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that comply with current standards for medically necessary covered services, cost effectiveness, and least restrictive environment.

Residential Treatment Center Authorization Criteria

A. PURPOSE

Level One psychiatric residential treatment facility (RTC) services provide treatment for children and adolescents who demonstrate severe and persistent psychiatric disorders, when outpatient services (ambulatory care) in the community do not meet their treatment needs and they require services at a psychiatric residential treatment facility under the direction of a psychiatrist. These services are designed for children and adolescents who have significant deficits in social, behavioral, psychiatric, and psychological functioning and who require active treatment in a controlled environment with a high degree of psychiatric oversight, 24 hour nursing presence, effective program and treatment availability, and continuous supervision provided by professional behavioral health staff.

Admissions to a RTC are not emergent or urgent and are always prior service will no longer be needed. OR authorized. As per ADHS/DBHS Policy Manual Section 3.14 Securing Services and Prior Authorization, "prior authorization seeks to ensure that persons are treated in the most appropriate, most cost effective, and least restrictive setting, with sufficient intensity of service, treatment and supervision to safely and adequately treat the person's behavioral health condition." Such admissions are only appropriate where outpatient care has failed or where service will no longer be needed.

OR the child's/adolescent's psychiatric treatment needs are so severe they can only be met by the degree of specialized professional treatment available in a RTC. Active treatment focuses on specific targeted goals identified by the Child and Family Team, and are designed to enable the child/adolescent to be discharged from the psychiatric residential treatment facility at the earliest possible time. A lack of available outpatient services is not in and of itself the sole criterion for admission to a RTC.

Determination of the need for services is based on the federal regulations in 42 CFR:

§ 441.152 Certification of need for services.

A team specified in § 441.154 must certify that—

- (a) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;*
- (b) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and*
- (c) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.*

§ 441.154 Active treatment.

Inpatient psychiatric services must involve "active treatment", which means implementation of a professionally developed and supervised individual plan of care, described in § 441.155 that is—

- (a) Developed and implemented no later than 14 days after admission; and*
- (b) Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.*

B. BEHAVIOR AND FUNCTIONING REQUIRED FOR ADMISSION

1. Symptoms or functional impairments of the individual's psychiatric condition are of a severe and persistent nature, are consistent with a DSM IV-TR diagnosis (within the range of 290 through 316.99), and require residential 24-hour psychiatric treatment under the direction of a psychiatrist.
 - a) Psychiatric conditions best described as 314.xx (Attention Deficit/Hyperactivity Disorder) and 312.8 (Conduct Disorder), without another DSM IV-TR co-morbid diagnosis, are not properly treated at a psychiatric residential treatment facility as per *Mental Health: A Report of the Surgeon General* and therefore should be closely reviewed for appropriateness of treatment in this level of care.
2. In addition, **all** of the following must be met to ensure appropriate, cost-effective and least restrictive care in this setting:
 - a) Ambulatory care resources (outpatient medically necessary behavioral health services) in the community do not meet the treatment needs of the child/adolescent;
 - b) The child/adolescent does not require a level of medical or professional

supervision that surpasses that which is available at a Level I Residential Treatment Center. For example, children/adolescents actively showing signs of danger to self or danger to others may require inpatient psychiatric treatment at an acute psychiatric hospital;

c) The admission is **not** used primarily, and in a clinically inappropriate manner, as:

i) an alternative to incarceration, preventative detention, or as a means to ensure community safety in a child/adolescent exhibiting primarily delinquent/antisocial behavior; or

ii) the equivalent of safe housing, permanency placement, or

iii) an alternative to parents'/guardian's or other agency's capacity to provide for the child or adolescent; or

iv) an intervention when other less restrictive alternatives are available and not being utilized.

C. EXPECTED IMPROVEMENT DUE TO ACTIVE TREATMENT

Active treatment with the services available at this level of care can reasonably be expected to improve the child/adolescent's psychiatric condition in order to achieve discharge from the psychiatric residential treatment facility at the earliest possible time and facilitate his/her return to outpatient care and/or family living.

D. DISCHARGE PLAN

There is a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that includes involvement of the Child and Family Team and complies with current standards for medically necessary covered behavioral health services, cost effectiveness

Residential Treatment Center Continued Authorization Criteria

A. PURPOSE

Level One psychiatric residential treatment facility (RTC) services provide treatment for children and adolescents who demonstrate severe and persistent psychiatric disorders, when outpatient services (ambulatory care) in the community do not meet their treatment needs and they require services under the direction of a psychiatrist at a psychiatric residential treatment facility. These services are designed for children and adolescents who have significant deficits in social, behavioral, psychiatric, and psychological functioning and who require active treatment in a controlled environment with a high degree of psychiatric oversight, 24 hour nursing presence, effective program and treatment availability and continuous supervision provided by professional behavioral health staff. Continued stays in a RTC are not emergent or urgent and are always prior authorized. As per ADHS/DBHS Policy Manual Section 3.14 Securing Services and Prior Authorization, "prior authorization seeks to ensure that persons are treated in the most appropriate, most cost effective, and least restrictive setting, with sufficient intensity of service, treatment and supervision to safely and adequately treat the person's behavioral health condition." Such admissions are only appropriate where outpatient care has failed or where

the child's/adolescent's psychiatric treatment needs are so intense that they can only be met by the degree of specialized professional treatment available in a RTC. Active treatment focuses on specific targeted goals identified by the Child and Family Team, and are designed to enable the child/adolescent to be discharged from the psychiatric residential treatment facility at the earliest possible time. A lack of available outpatient services is not in and of itself the sole criterion for continued stay at a RTC. If a child/adolescent receiving services no longer requires this level of care, but services suitable to meet his/her behavioral health needs are not available or he/she cannot return to his/her previous residence because of a risk of harm to self or others, services may continue to be authorized with an, active attempt to secure a suitable discharge placement or residence.

Determination of the need for services is based on the federal regulations in 42

CFR: § 441.152 Certification of need for services.

(a) A team specified in § 441.154 must certify that—

- (1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;*
- (2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and*
- (3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.*

§ 441.154 Active treatment.

Inpatient psychiatric services must involve “active treatment”, which means implementation of a professionally developed and supervised individual plan of care, described in § 441.155 that is—

- (a) Developed and implemented no later than 14 days after admission; and*
- (b) Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.*

B. BEHAVIOR AND FUNCTIONING REQUIRED FOR CONTINUED STAY:

1. The symptoms or functional impairments of the individual's psychiatric condition are of a severe and persistent nature, are consistent with a DSM IVTR diagnosis (within the range of 290 through 316.99), and continue to require residential 24-hour psychiatric treatment under the direction of a psychiatrist.
 - a) Psychiatric conditions best described as 314.xx (Attention-Deficit/Hyperactivity Disorder) and 312.8 (Conduct Disorder) are not properly treated at a psychiatric residential treatment facility as per *Mental Health: A Report of the Surgeon General* and therefore should be closely reviewed for appropriateness of treatment in this level of care.
2. In addition, **all** of the following must be met to ensure appropriate, cost-effective and least restrictive care in this setting:
 - a) Ambulatory care resources (outpatient medically necessary behavioral health services) in the community do not meet the treatment needs of the

child/adolescent;

b) The child/adolescent does not require a level of medical or professional behavioral health supervision that surpasses that which is available at a Level I Residential Treatment Center. For example, children/adolescents actively showing signs of danger to self or danger to others may require inpatient psychiatric treatment at an acute psychiatric hospital;

c) The continued stay is not used primarily and in a clinically inappropriate manner as:

i) an alternative to incarceration, preventative detention, or as a means to ensure community safety in a child/adolescent exhibiting primarily delinquent/antisocial behavior;

ii) the equivalent of child protection, safe housing, permanency placement, or

iii) an alternative to parents'/guardian's or other agency's capacity to provide for child or adolescent; or

iv) an intervention when other outpatient care is available and not being utilized.

C. EXPECTED IMPROVEMENT DUE TO ACTIVE TREATMENT

The child/adolescent is receiving services which are improving his/her psychiatric condition in order to achieve discharge from residential status at the earliest possible time and facilitate his/her return to outpatient care and/or family living. The professionally developed and supervised individual service plan has been changed (revised) if necessary to respond to any identified lack of progress.

D. DISCHARGE PLAN

There is a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that includes involvement of the Child and Family Team and complies with current standards for medically necessary covered behavioral health services, cost effectiveness, and least restrictive environment and is in conformance with 42 CFR.

Level II Group Home Authorization Criteria for Children Under the Age of 21

Background

The Arizona Vision and 12 Practice Principles clearly articulate as a core value that services be provided in the most appropriate, integrated setting responsive to the child's needs. At the same time, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) recognizes that there are children/youth whose needs, in spite of intensive community-based service provision, can only be adequately and safely addressed through the use of targeted, short-term out of home treatment intervention. When community-based services are not effective in maintaining the child in his/her home setting, or safety concerns become critical, the use of out of home treatment services can provide essential behavioral health interventions to stabilize the situation.

Service Expectations:

For services requiring prior authorization, if the prior authorization is denied the T/RBHA must assist the CFT with recommendations of alternative services that are congruent with the child's/family's needs.

Service Plans must include goals and objectives that prepare the child and family for the child's return to home or to a less restrictive community setting, as quickly as possible.

Every child receiving treatment services in an out of home setting must be served through a Child and Family Team, and the Residential Service Provider and CFT Service Plans must be in alignment.

Family involvement and partnership, including the provider's attempts to engage the family, must be clearly documented in the clinical record.

Residential service provider staff must be trained and supervised to ensure treatment interventions and service plans are being implemented effectively. All staff directly involved with the child's care must receive regularly scheduled clinical supervision, as well as event-driven supervision when necessary, to ensure the provision of sound clinical treatment.

Residential service providers must work collaboratively with the CFT to identify and address the changing needs of the child and family. Treatment interventions and services are modified as needed.

All behavioral health staff who provide out of home treatment services must complete required training per ADHS/DBHS Provider Manual Section 9.1, Training Requirements and OBHL guidelines.

For both planned and unplanned admissions, concurrent review must occur within three business days of the recipient's admission and services must not be authorized for more than three business days per review. ADHS/DBHS conducts retrospective review on 100% of inpatient stays for which ADHS/DBHS was not notified of the Tribal Recipient's admission. For such cases, ADHS/DBHS reviews documentation gathered from the facility, discusses the cases with facility staff, and then makes a decision regarding whether the stay was medically necessary. When reviewing a case retrospectively, ADHS/DBHS and its Contractors are required to apply the same criteria used to make the initial and continued stay decisions. Retrospective reviews must occur within twenty-eight (28) business days from the receipt of notification.

All ADHS/DBHS staff that completes prior authorization, concurrent review, and retrospective review participates in inter-rater reliability exercises to ensure consistency in decision making. Inter-rater reliability testing is conducted biannually to monitor consistency across staff, with additional training provided to reviewers do not appropriately apply authorization criteria. The results of inter-rater reliability testing are

presented in the MM/UM Committee. Both staff that presently completes authorizations are also responsible for concurrent and retrospective reviews.

RBHAs Prior Authorization, Concurrent Review and Retrospective Review

ADHS/DBHS delegates Prior Authorization, Concurrent Review and Retrospective Review to its RBHAs/Contractors. Contractors must comply with AHCCCS Medical Policy Manual and the requirements and criteria (same as above) documented in ADHS/DBHS [Provider Manual Section 3.14, Securing Services and Prior Authorization](#), Policy 3.0, Concurrent Review, and Policy 2.9, Retrospective Review. All three policies specify the type of staff that is permitted to conduct prior authorization, concurrent review, and retrospective review. The policies also require Contractors to have systems in place that incorporate:

- A) The use of criteria when making medical necessity determinations;
- B) Policies and procedures that address the medical necessity of ongoing hospital stays;
- C) Policies and procedures that incorporate approval and denial of services;
- D) Policies and procedures that address review of medical necessary hospitalizations (planned hospitalizations)
- E) Length of stay criteria;
- F) Discharge criteria that is inclusive of the recipient's needs at the time of discharge;
- G) Evaluation of the quality of services provided;
- H) Whether the services provided met the Recipient's needs;
- I) Which clinical documents must be obtained and reviewed;
- J) The time requirements for conducting prior authorizations, concurrent review, and retrospective review
- K) Facility and recipient based utilization patterns and analysis; and
- L) Concurrent review staff's role in managing a recipient who has another primary payer. At a minimum, the staff must participate in the discharge planning process.

Staff requirements for staff conducting prior authorization, concurrent review, and retrospective review are specific. At a minimum:

- A) Staff must be qualified behavioral health professionals, RN/BSH, nurse practitioners, physician assistants, and/or physicians to execute the authorization functions.
- B) Staff must be adequate in number to ensure timely reviews.
- C) Staff participating in medical necessity determinations must be tested to ensure consistency in the application of standardized criteria.
- D) In the event that a staff does not follow the established criteria and/or timelines, the Contractor must have a system in place to provide additional education/training and monitoring of the staff to remedy the discrepancy in a manner which ensures the integrity of the criteria is maintained.

The Office of MM/UM reviews all Medical Management specific policies and criteria at least annually through the Policy Committee and presents any changes made to the policies to the MM/UM Committee for approval prior to implementation.

As required by AHCCCS contract with ADHS/DBHS, the Division sends a monthly Grievance System Report to AHCCCS that is inclusive of the number of prior authorizations and denials for all levels of care. The monthly MM/UM report is reported in the MM/UM Committee to identify areas of needed improvement across the system. In addition, ADHS/DBHS evaluates its Contractors' compliance with prior authorization and concurrent review requirements via chart reviews during the Annual Administrative Review. If areas in need of improvement are identified, Contractors are required to submit a plan for improvement using the [QM Corrective Action Plan \(CAP\) Template](#) which is approved by ADHS/DBHS and monitored through completion.

ADHS/DBHS assesses Notices of Action (NOAs) to ensure compliance with NOA requirements and to ensure that decisions are meeting clinical decision making expectations. Although reviewed monthly, NOA data is presented to the MM/UM Committee on a quarterly basis for feedback and recommendations.

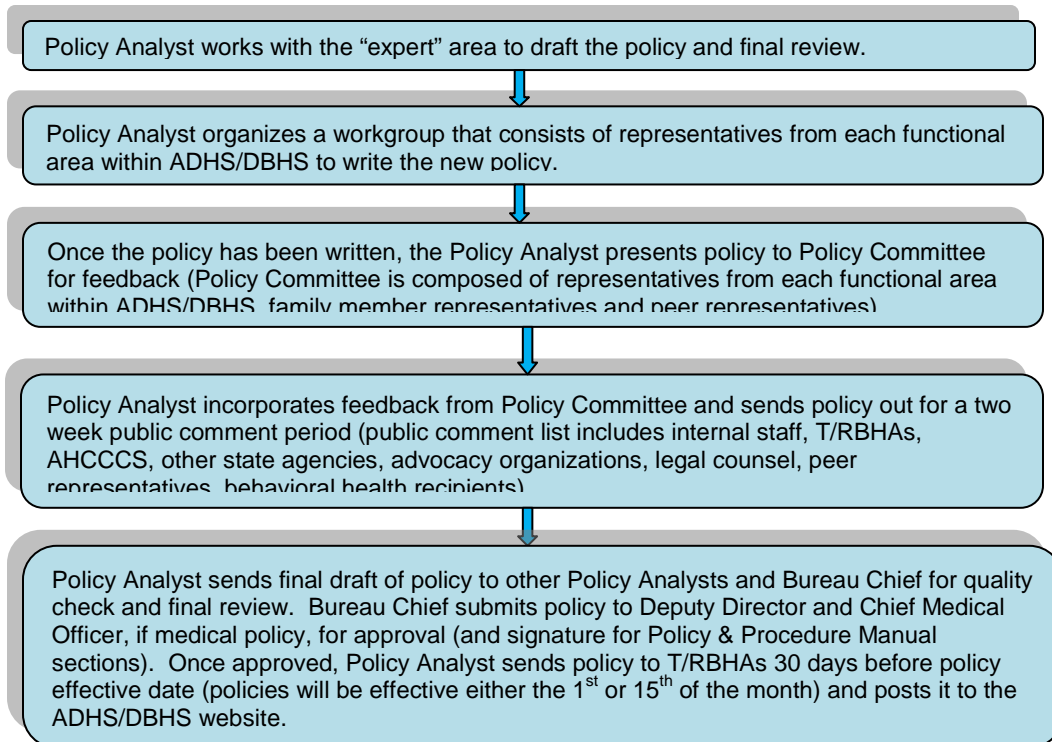
During the Annual Administrative Review, ADHS/DBHS will review its Contractor's Inter-rater reliability testing results for staff involved in authorization decision making. As per ADHS/DBHS policy, all new staff should complete IRR testing within 90-days of hire (including RBHAs' Medical Directors), and testing must be repeated annually thereafter. A minimum performance score of 90 percent is acceptable for meeting this requirement. ADHS/DBHS will also monitor to ensure that staff who do not achieve the minimum performance score receive IRR training and are re-evaluated for meeting the requirement.

Contractors are required to submit a quarterly Showing Report, per ADHS/DBHS [Policy and Procedures, Section QM 2.2, Showing Report](#), attesting to their compliance with 42 CFR 456.650 regarding certification of need for inpatient hospitalizations. ADHS/DBHS reviews this information for completeness and accuracy and forwards the Showing Report to AHCCCS.

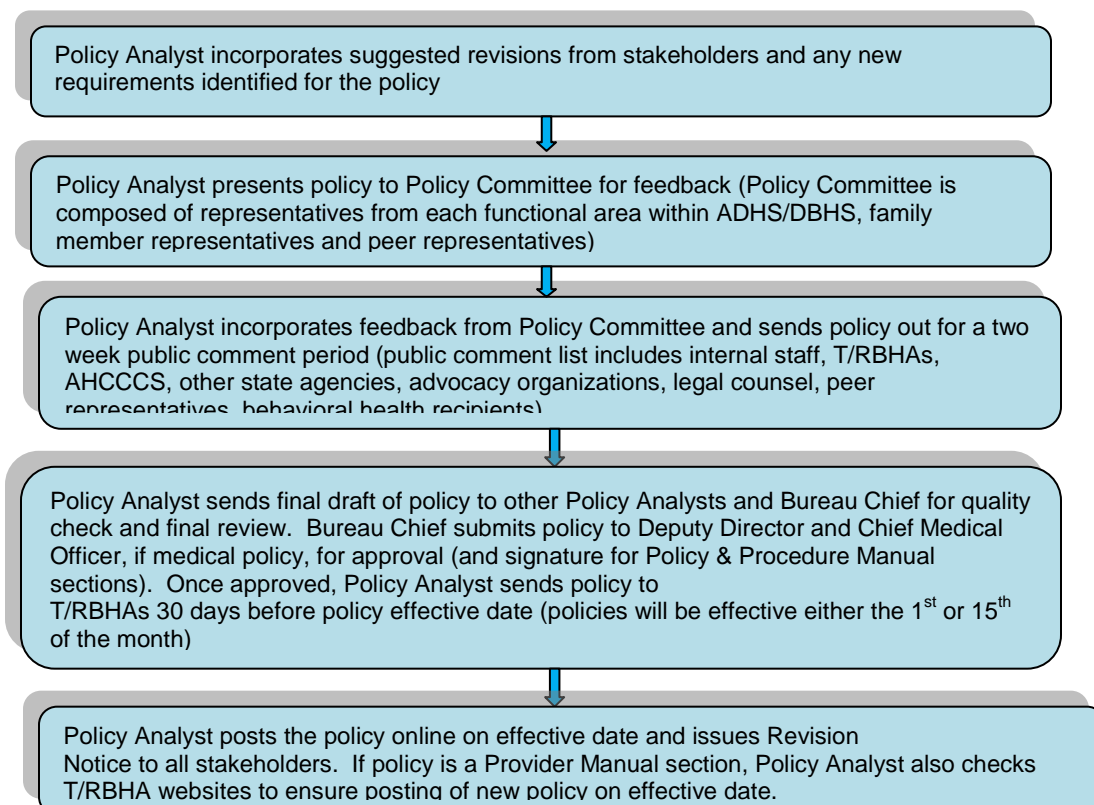
Adoption and Dissemination of Policies and Procedures (including Revisions to existing Policies)

ADHS/DBHS maintains an inclusive approach when developing new policies and procedures, as well as reviewing and revising existing policies. The ADHS/DBHS Policy Department presents all newly proposed policies to the Policy Committee, and tracks all existing policies to ensure that they are reviewed at least annually. The Policy Committee consists of representation from all areas within ADHS/DBHS, providers, recipients, and other stakeholders who have vested interest. After the policy committee's review, each policy is sent out for public comment and comments are reviewed by the appropriate functional area within ADHS/DBHS, as presented in the flow chart below. All MM/UM policies are reviewed by the MM/UM Committee for final approval.

CREATION OF NEW POLICY PROCESS



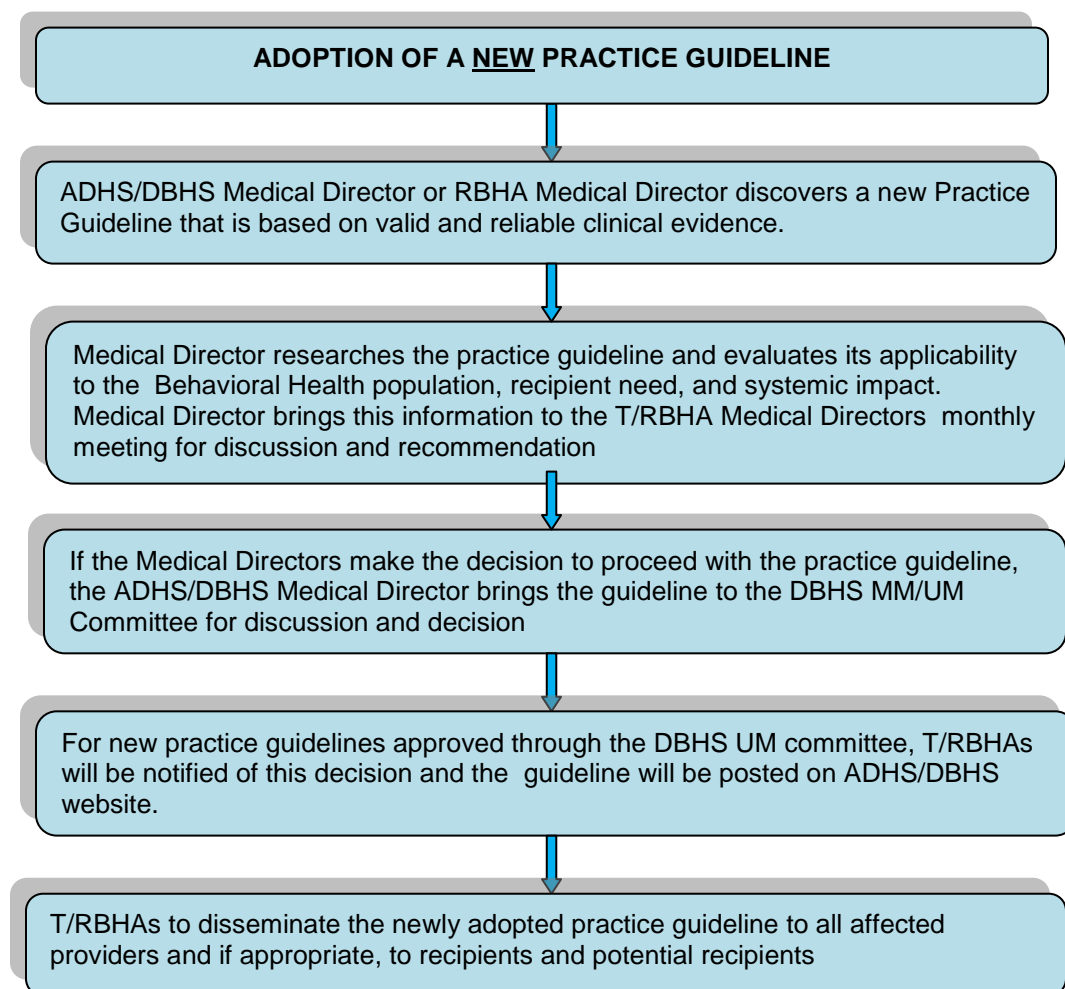
ANNUAL REVIEW/REVISION PROCESS

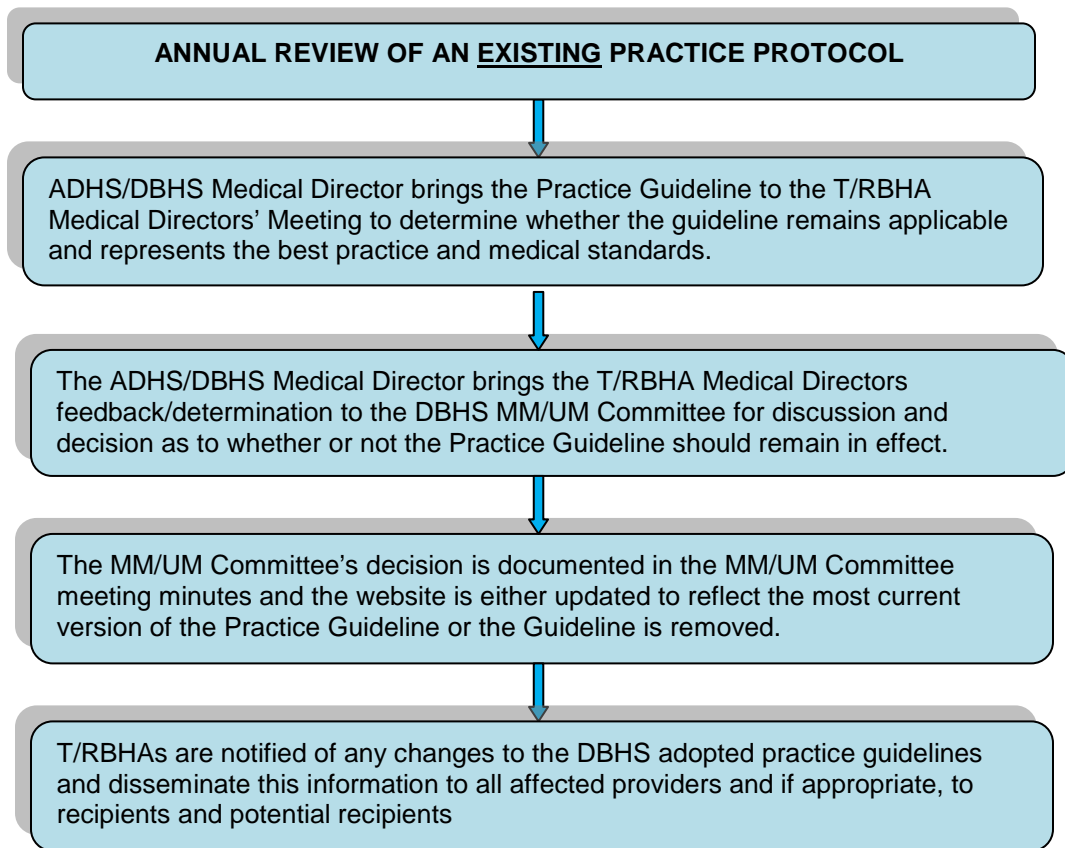


Adoption and Dissemination of Evidence-based Practice Protocols

Behavioral Health does not have Practice Guidelines like Acute Care; however, ADHS/DBHS ensures that clinical guidance documents and policies include nationally accepted evidence-based practice approaches, and are developed and disseminated for use by Contractors in providing care. ADHS/DBHS works with its Contractors' Medical Directors to develop practice protocols and stakeholder feedback is obtained prior to implementation; and to ensure that these protocols direct practice across the state, educate behavioral health recipients and providers, and enhance service delivery. Practice Protocols are incorporated by reference into applicable sections of the ADHS/DBHS Provider Manual. [Clinical Practice Protocols](#) and [National Practice Guidelines](#) are available on the ADHS/DBHS website. The following diagram reflects the process for adopting new Practice Protocols and conducting annual reviews of existing Practice Protocols. ADHS/DBHS organizes the documents in the categories:

- [Clinical Practice Protocols with Required Elements](#);
- [Clinical Practice Protocols without Required Elements](#); and
- [National Clinical Practice Guidelines](#).





Care Coordination

Care Coordination is delegated to the T/RBHAs. Contractors must follow policies and procedures related to the provision of care coordination services, per the following ADHS/DBHS Provider Manual sections:

- [Section 3.8, Outreach, Engagement, Re-engagement, and Closure;](#)
- [Section 3.9, General and Informed Consent to Treatment;](#)
- [Section 3.17, Transitions of Persons;](#)
- [Section 3.19, Special Populations;](#)
- [Section 4.3, Coordination of Care with AHCCCS Health Plans and Primary Care Providers;](#)
- [Section 4.4, Coordination of Care with Other Governmental Entities;](#)
- [Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons;](#)
- [Section 5.2, Member Complaints;](#)
- [Section 5.4, Special Assistance for Persons Determined to have a Serious Mental Illness;](#) and
- [Section 5.5, Notice and Appeal requirements \(SMI and Non-SMI/Non-Title XIX/XXI\).](#)

Although ADHS/DBHS does not directly provide Care Coordination, Care Coordination monitoring occurs through a variety of mechanisms including but not limited to the following:

- The analysis of the AHCCCS/ADHS/DBHS Coordination of Care performance measure;
- Submission of Transition Logs;
- Through the Quality of Care Concern (QOC) process ; and,
- Data Validation Activities.

ADHS/DBHS requires its Contractors to include the position of Health Plan Coordinator in its staffing structure. This position coordinates and tracks the sharing of information on referrals and communication between the AHCCCS Acute Health Plans and the ADHS/DBHS Contractors.

ADHS/DBHS requires its Contractors to identify behavioral health recipients in need of intensive monitoring and support. Contractors must provide or arrange for intensive monitoring of individuals identified as at risk for higher levels of care, frequent crises, or recipients under court order. The Quality Improvement Office reports coordination of care outcomes to the MM/UM Committee.

III. Delegated Activities

(AMPM Chapter 1000, Policy 1020(C), Contract ¶ 41)

ADHS/DBHS delegates the following MM/UM functions to its Contractors as delineated in the ADHS/DBHS/RBHA contracts:

- A comprehensive MM/UM program that includes all the required components within the ADHS/DBHS MM/UM Plan; the AHCCCS AMPM Chapter 1000, and the ADHS/DBHS/RBHA Contracts;
- Prior Authorization, Concurrent Review, and Retrospective Review, Inter-rater reliability
- Over and Under Utilization Monitoring
- Pharmacy Utilization Review
- Care Coordination/Case Management

ADHS/DBHS provides oversight and has ultimate accountability for all functions delegated to its Contractors. Contractor monthly, quarterly and ad hoc reports, ADHS/DBHS focused reviews, data validation exercises and the Annual Administrative Review serve as the mechanisms by which ADHS/DBHS monitors delegated functions. Furthermore, the Contractors must complete the following for any activities they delegate to their providers:

- Evaluate the entity's ability to perform the delegated activities prior to delegation;
- Execute a written agreement that specifies the delegated activities and reporting responsibilities of the entity that incorporates revocation of the delegation or other remedies for inadequate performance;
- Monitor the performance and quality of services provided on an ongoing basis, including an annual formal review;

- Evaluate qualification of Medical Management staff that performs delegated activities.

IV. Reporting Requirements

(AMPM Chapter 1000, Policy 1020(C))

ADHS/DBHS reports all AHCCCS deliverables per the AHCCCS/ADHS/DBHS contract schedule. ADHS/DBHS requires all Contractors to report MM/UM data at least quarterly.

ADHS/DBHS MM/UM Reporting to AHCCCS

- Annual MM/UM Plan, Work Plan and Evaluation
- Quarterly Showing Report

Contractor MM/UM Reporting to ADHS/DBHS

- Annual Contractor MM/UM Plan, Work Plan and Evaluation
- Annual Contractor Medical Care Evaluation Studies
- Biannual Recipient and Provider Over and Under Utilization Reports
- Quarterly Showing Report
- Quarterly MM/UM Report
- Quarterly SMI Eligibility Data
- Quarterly Court Ordered Treatment Data
- Quarterly Pharmacy Utilization Logs
- Monthly Prior Authorization Data
- Monthly Transition Logs
- Monthly Length of Stay/Readmissions Data

ADHS/DBHS ensures all deliverables are submitted to AHCCCS in a timely manner and are complete and error free. ADHS/DBHS Contractors must submit timely, logical and error free reports to ADHS/DBHS for the compilation of statewide reports to AHCCCS. ADHS/DBHS MM/UM reports are reviewed by the ADHS/DBHS Leadership Team for approval before submission to AHCCCS.

V. Conclusion

The ADHS/DBHS Office of Medical Management/ Utilization Management is committed to not only reviewing practices related to resource utilization, but also to taking action to modify inappropriate, inefficient or ineffective utilization. Many of ADHS/DBHS' Medical Management/Utilization Management's goals and functions are reliant on coordination with Contractors and other functional areas within the agency including but not limited to: Quality Management, Network Management, Bureau for Consumer Rights, Finance, the Data Department and various committees. The Office of Medical Management/Utilization Management recognizes their participation in success of this Medical Management/Utilization Management Plan and program.

Attachments

- A. 2011 Medical Management/Utilization Management Work Plan Evaluation (*Not resubmitted per AHCCCS request*)
- B. 2012 Medical Management/Utilization Management Plan
- C. 2012 Medical Management/Utilization Management Work Plan
- D. UM Plan Checklist
- E. Resume-Office Chief Office of Medical Management: Alexandra O'Hannon
- F. MM/UM Plan- Committee Approval
- G. MM/UM Plan- Chief Medical Officer
- H. MM/UM Plan- Leadership Team Approval

ADHS/DBHS 2012 Work Plan

Goals: 1. Prior Authorization Process times will be in compliance with AHCCCS guidelines at least 98 percent of the time. 2. Notice of Action process will be in compliance with AHCCCS guidelines at least 90 percent of the time. 3. Achieve a minimum Authorization Inter-rater review score of 90 percent among all reviewers.							
Area of Review/Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/ Analysis of Intervention	Next Review	Comments	Results/ Outcomes
1. Prior Authorizations will meet the timelines established by AHCCCS through the monthly monitoring of prior authorization data: <ul style="list-style-type: none"> Standard Expedited Expedited Changed to Standard 	TRBHAs prior authorizations are conducted in house by ADHS/DBHS staff. The MM/UM Office Chief will ensure that: <ul style="list-style-type: none"> Authorizations for hospitalizations, RTC, and Level II therapeutic group homes are received from three contracted TRBHAs (Gila River, White Mountain and Pascua Yaqui) and Navajo Nation via fax or mail. Two full time dedicated ADHS/DBHS staff will conduct authorization reviews Mon-Fri. from 8:00 am - 5:00 pm. Staff will use medical necessity coverage criteria based on nationally recognized, evidence based practices. Staff will complete authorizations within the timeframes allotted for standard, expedited, and expedited changed to standard requests. MM/UM Office Chief will conduct Inter-Rater Reliability (IRR) testing twice a year for both staff involved in authorization process to ensure consistency in making decisions specific to medical necessity. About 10% sample per each category of authorization (hospitalizations, RTC, and Level II therapeutic group homes) will be randomly selected for both staff; cases will be reviewed independently by each staff, including the Office Chief, findings will be compared to check for inconsistencies. ADHS/DBHS Authorization staff will be monitored by the Office Chief to ensure that there are no delays and authorizations are timely. Training will be provided to ADHS/DBHS staff based on their performance. 	MM/UM Office Chief					

- Goals:**
1. Prior Authorization Process times will be in compliance with AHCCCS guidelines at least 98 percent of the time.
 2. Notice of Action process will be in compliance with AHCCCS guidelines at least 90 percent of the time.
 3. Achieve a minimum Authorization Inter-rater review score of 90 percent among all reviewers.

Area of Review/Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/ Analysis of Intervention	Next Review	Comments	Results/ Outcomes
	<p>RBHAs Prior Authorizations are delegated to RBHAs; ADHS/DBHS will:</p> <ul style="list-style-type: none"> • ADHS/DBHS receive authorization flat file data from the RBHAs on a monthly basis. • Data is analyzed and an authorization report is generated that reflects a component of statewide Enrollee Grievance Report. • Findings of the above report will be presented in the MM/UM Committee for feedback and recommendations. • All Contractors who do not achieve a score of 98% will receive technical assistance until such time that the desired score is received. • In the event that technical assistance has been provided and the Contractor continues to fail to meet the 98% compliance score, the Contractor will be placed on a CAP until such time that the desired score is achieved. • ADHS/DBHS submits prior authorization data to AHCCCS on the <i>Authorization Request and Appeal Report</i> on a quarterly basis (a section in Enrollee Grievance Report). • ADHS/DBHS conducts data validation of RBHAs authorizations on a biannual basis <ul style="list-style-type: none"> ▪ This action will include the random selection of a minimum of 35 cases to be reviewed per quarter. ▪ Validation checklist includes accuracy of decisions, timeliness, accuracy of type of request, and verification of authorizations. ▪ Score is computed and any Contractor who does not achieve a minimum score of 90% will be placed on a Corrective Action Plan (CAP). ▪ MM/UM Office Chief will monitor the Contractor's CAP until they achieve a score of at least 90% on future validation tests for this flat 	MM/UM Office Chief					

- Goals:**
1. Prior Authorization Process times will be in compliance with AHCCCS guidelines at least 98 percent of the time.
 2. Notice of Action process will be in compliance with AHCCCS guidelines at least 90 percent of the time.
 3. Achieve a minimum Authorization Inter-rater review score of 90 percent among all reviewers.

Area of Review/Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/ Analysis of Intervention	Next Review	Comments	Results/ Outcomes
	file						
2. Ensure ADHS/DBHS Authorization Staff complete Concurrent Reviews and Retrospective Reviews as appropriate.	<p>For TRBHAs Concurrent and Retrospective Reviews, ADHS/DBHS-MM/UM Office Chief will review:</p> <ul style="list-style-type: none"> • Concurrent and retrospective reviews for hospitalizations and RTC are received from the facility via fax or email. • Two full time dedicated ADHS/DBHS staff will conduct reviews Mon- Fri from 8:00 am -5:00 pm. • Staff will use medical necessity coverage criteria based on nationally recognized, evidence based practices. • Staff will complete concurrent and retrospective reviews within the timeframes allotted by ADHS/DBHS policy QM2.9 and QM 3.0. • ADHS/DBHS Authorization staff will be monitored by the Office Chief to ensure that there are no delays in processing the concurrent and retro reviews and all timelines are met. • A 10% sample of concurrent review and retrospective review files are randomly selected on a biannual basis to ensure staff are using standardized concurrent review and retrospective medical necessity criteria when making medical necessity determinations. • Training will be provided for any staff that fails to achieve a minimum score of 90% in the evaluation. 	MM/UM Office Chief					
3. Monitor the RBHAs Concurrent Review and Retrospective Review processes at least annually	<p>RBHAs Concurrent and Retrospective Review processes are delegated to RBHAs; ADHS/DBHS will:</p> <ul style="list-style-type: none"> • Conduct reviews of Contractors' concurrent review and retrospective review processes during the Annual Administrative Review to ensure that: <ul style="list-style-type: none"> ○ Qualified staff are making medical necessity decisions by confirming documents are signed by 	MM/UM Office Chief					

Goals: 1. Prior Authorization Process times will be in compliance with AHCCCS guidelines at least 98 percent of the time. 2. Notice of Action process will be in compliance with AHCCCS guidelines at least 90 percent of the time. 3. Achieve a minimum Authorization Inter-rater review score of 90 percent among all reviewers.							
Area of Review/Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/ Analysis of Intervention	Next Review	Comments	Results/ Outcomes
	a licensed behavioral health professional (BHP). ○ Concurrent review and retrospective review policies and procedures are in place that incorporate inter rater reliability practices. ○ Standardized medical necessity coverage criteria based on nationally recognized, evidence based practices are being used for medical necessity determinations as adopted by ADHS/DBHS.						
Goal #2: Notice of Action process will be in compliance with AHCCCS guidelines at least 90 percent of the time.							
	RBHA and TRBHA NOAs are treated equally. ADHS/DBHS will: <ul style="list-style-type: none"> Review Notice of Actions on a quarterly basis for adherence to AHCCCS and ADHS/DBHS requirements by using the AHCCCS NOA Audit Checklist. Organize a Notice of Action Review Group (which will include all RBHAs) to conduct IRR on NOAs review by each RBHA. Facilitate a group meeting at least quarterly during FY 2012 to ensure NOAs meet AHCCCS requirements. Provide Technical Assistance and or CAPs for any Contractor who fails to achieve a score of at least 90% when using the AHCCCS NOA Audit Checklist. Present the results of the NOA reviews to the MM/UM Committee quarterly for recommendations. 	MM/UM Office Chief/ Margery Ault/Kara Burk					
2. Ensure that the clinical rationale for denying a	ADHS/DBHS-MM/UM Office Chief and the CMO will: <ul style="list-style-type: none"> Conduct Clinical reviews of Notices of Actions on a 	MM/UM Office Chief					

Goals: 1. Prior Authorization Process times will be in compliance with AHCCCS guidelines at least 98 percent of the time. 2. Notice of Action process will be in compliance with AHCCCS guidelines at least 90 percent of the time. 3. Achieve a minimum Authorization Inter-rater review score of 90 percent among all reviewers.							
Area of Review/Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/ Analysis of Intervention	Next Review	Comments	Results/ Outcomes
service is appropriate.	quarterly basis in consultation with the Medical Director (if necessary) to ensure that reason for denial is appropriate. <ul style="list-style-type: none"> Present outcomes of the clinical review to the MM/UM Committee at least quarterly for recommendations. In the event that the clinical rationale is not appropriate, action will be taken as needed. 						
Goal # 3: Achieve a minimum Prior Authorization Inter-rater review score of 90 percent among all reviewers.							
1. Ensure consistency in Authorizations by conducting I Inter-Rater Reliability testing among ADHS/DBHS staff who are involved in the Prior Authorization process.	<u>ADHS/DBHS Authorization Staff</u> MM/UM Office Chief will: <ul style="list-style-type: none"> MM/UM Office Chief will conduct Inter-Rater Reliability (IRR) testing twice a year for both staff involved in authorization process to ensure consistency in making decisions specific to medical necessity. About 10% sample per each category of authorization (hospitalizations, RTC, and Level II therapeutic group homes) including concurrent and retro reviews will be randomly selected for both staff; cases will be reviewed independently by each staff, including the Office Chief, findings will be compared to check for inconsistencies. In the event that staff does not achieve a score of 90 percent, staff will receive training and supervision until such time that a minimum score of 90 percent is achieved. 	MM/UM Office Chief					
2. Ensure consistency in Authorizations by monitoring Contractor Inter-rater reliability results.	ADHS/DBHS MM/UM will require Contractors to submit their Inter-rater Reliability policy to confirm that policy includes: <ul style="list-style-type: none"> IRR testing is conducted within 90-days of hire for all staff involved in medical necessity determination 	MM/UM Office Chief					

Goals: 1. Prior Authorization Process times will be in compliance with AHCCCS guidelines at least 98 percent of the time. 2. Notice of Action process will be in compliance with AHCCCS guidelines at least 90 percent of the time. 3. Achieve a minimum Authorization Inter-rater review score of 90 percent among all reviewers.							
Area of Review/Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/ Analysis of Intervention	Next Review	Comments	Results/ Outcomes
	(including RBHAs Medical Director), and testing must be repeated annually thereafter. <ul style="list-style-type: none"> • Minimum performance scores for Inter-rater reliability testing are identified and meet ADHS requirements of 90 percent. • Training requirements for staff who do not achieve the minimum performance score. • ADHS/DBHS monitor Contractor Inter-rater reliability results and actions during the Annual Administrative Review process. 						

ADHS/DBHS 2012 Work Plan

Goals: 4. Utilization data will be monitored on a monthly basis for accuracy and timeliness of submission.
5. ADHS/DBHS will conduct monitoring of the RBHAs over and under utilization on a biannual basis.

Area of Review/ Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/Analysis of Intervention	Next Review	Comments	Results/ Outcomes
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Goal # 4: Utilization Data Analysis and Data Management and Drug Utilization							
1. Ensure RBHAs turn in accurate and timely utilization data. Data reviewed will consist of at a minimum: <ul style="list-style-type: none"> • Authorizations • Pharmacy Utilization • SMI Eligibility • Length of Stay/ Re-admission • COT data 	RBHAs submits utilization data to ADHS/DBHS on monthly and/or quarterly basis; ADHS/DBHS will continue to: <ul style="list-style-type: none"> • Track Contractors data submissions to ensure timely submission of flat files for: <ul style="list-style-type: none"> ○ Authorizations ○ Pharmacy Utilization ○ SMI Eligibility ○ Length of Stay/ Re-admission ○ Court Ordered Treatment (COT) data • Analyze data provided and compare it to the summary analysis provided by Contractors to ensure consistency. • Confirm data submissions are accurate (Error rate not to exceed 5 percent) • Ensure that all submissions not meeting the requirements (≤ 5 percent error rate) are returned for resubmission. • Take Corrective Action if pattern of inaccuracy is established. • Present data and analysis to the MM/UM Committee. 	MM/UM Office Chief/ OIM Office Chief					

ADHS/DBHS 2012 Work Plan

Goals: 4. Utilization data will be monitored on a monthly basis for accuracy and timeliness of submission.
5. ADHS/DBHS will conduct monitoring of the RBHAs over and under utilization on a biannual basis.

Area of Review/ Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/Analysis of Intervention	Next Review	Comments	Results/ Outcomes
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Goal # 5: ADHS/DBHS will conduct monitoring of the RBHAs over and under utilization on a biannual basis.							
1. Ensure that RBHAs monitor over and under utilization at individual and provider level.	RBHAs submit an over/under utilization of services report to ADHS/DBHS on biannual basis; MM/UM Office Chief will continue to: <ul style="list-style-type: none"> Require biannual over/under utilization reports from Contractors. Complete an analysis of the Contractors' over/under utilization data and narrative summary. Review Contractors' reports to confirm tracking and trending of over/under utilization at both individual and provider level. Conduct a comparative analysis between Contractors' over and under utilization for like services. Address outliers through technical assistance (TA) and corrective action process. Present trends identified during its monitoring of Contractors to the MM/UM Committee for recommendations. 	MM/UM Office Chief/ BQMO					
2. Conduct Data Validation on a biannual basis	ADHS/DBHS-MM/UM Office Chief will: <ul style="list-style-type: none"> ADHS/DBHS conduct data validation on a biannual basis during FY 2012 for all RBHA flat files to confirm that data received is valid and reliable. 	MM/UM Office Chief					

ADHS/DBHS 2012 Work Plan

- Goals:**
- 4. Utilization data will be monitored on a monthly basis for accuracy and timeliness of submission.
 - 5. ADHS/DBHS will conduct monitoring of the RBHAs over and under utilization on a biannual basis.

Area of Review/ Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/Analysis of Intervention	Next Review	Comments	Results/ Outcomes
	<ul style="list-style-type: none"> This will include the random selection of at least 35 cases for each of the following flat files: <ul style="list-style-type: none"> Prior Authorization Court Ordered Treatment SMI Eligibility LOS/Readmissions For <u>Authorizations</u> ADHS/DBHS uses a validation grid which includes accuracy of decisions, timeliness, accuracy of type of request, and verification of authorizations. For <u>COT</u>, ADHS/DBHS validates if the recipient was on COT, the type of COT and whether the recipient received a face to face assessment within one month prior to the expiration of COT. For <u>SMI Eligibility</u>, ADHS/DBHS validates whether the determination was made timely, reason for denial, denials are signed by a Medical Director. For <u>LOS/Readmit</u>, ADHS/DBHS validates the LOS was accurate as reported in the flat file, the readmission did occur within the reporting period, and the level of care was accurate. Scores are computed and any Contractor who does not achieve a minimum score of 90% will be placed on a Corrective Action Plan (CAP). MM/UM Office Chief will monitor the Contractor's CAP until they achieve a 						

ADHS/DBHS 2012 Work Plan

Goals: 4. Utilization data will be monitored on a monthly basis for accuracy and timeliness of submission.
5. ADHS/DBHS will conduct monitoring of the RBHAs over and under utilization on a biannual basis.

Area of Review/ Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/Analysis of Intervention	Next Review	Comments	Results/ Outcomes
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	<p>score of at least 90% on future validation tests for this flat file.</p> <ul style="list-style-type: none"> Contractors are expected to utilize data to promote timely and effective use of services. 						
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ADHS/DBHS 2012 Work Plan

Goals: 6. New Practice Guidelines will be adopted as clinically appropriate.

7. New Technologies and New Uses of Existing Technologies will be reviewed, discussed, and adopted as appropriate.

Area of Review/Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/ Analysis of Intervention	Next Review	Comments	Results/ Outcomes
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Goal # 6: New Practice Guidelines will be adopted as clinically appropriate.							
1. Ensure that new Practice Guidelines are adopted as clinically appropriate.	<p>ADHS/DBHS CMO will:</p> <ul style="list-style-type: none"> Continue to review <u>new guidelines</u> (as needed) in ADHS/RBHAs CMOs meeting utilizing ADHS/DBHS procedures (flow chart is documented in the 2012 MM/UM Plan). This will include: <ul style="list-style-type: none"> Researching the practice guideline and evaluating its applicability to the Behavioral Health population, recipient need, and systemic impact. Medical Director will bring this information to the T/RBHA Medical Directors' monthly meeting for discussion and recommendation. If a decision is made by the Medical Directors to proceed with the practice guideline, the ADHS/DBHS Medical Director will bring the guideline to the DBHS MM/UM Committee for discussion and final decision. ADHS/DBHS will notify T/RBHAs of a decision to adopt a new guideline; guidelines will be posted on the ADHS/DBHS website. ADHS/DBHS will ensure that T/BHAS disseminate the newly adopted practice guideline to all affected providers and if appropriate, to recipients and potential recipients by confirming that the T/RBHAs have posted the guidelines on the website). Ensure that AHCCCS is notified about any newly 	MM/UM Office Chief/ ADHS/ DBHS CMO					

ADHS/DBHS 2012 Work Plan

Goals: 6. New Practice Guidelines will be adopted as clinically appropriate.
7. New Technologies and New Uses of Existing Technologies will be reviewed, discussed, and adopted as appropriate.

Area of Review/Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/Analysis of Intervention	Next Review	Comments	Results/Outcomes
	<p>adopted practice guidelines.</p> <ul style="list-style-type: none"> ADHS/DBHS will conduct Annual Reviews for <u>existing Practice Guidelines</u> to ensure that they remain applicable and represent the best practice and medical standards. The process for review of existing guidelines is similar manner as for the new guidelines: <ul style="list-style-type: none"> ADHS/DBHS Medical Director will bring the Practice Guideline to the T/RBHA Medical Directors' Meeting to determine whether the guideline remains applicable and represents the best practice and medical standards. The ADHS/DBHS Medical Director will bring the T/RBHA Medical Directors. feedback/determination to the DBHS MM/UM Committee for discussion and decision as to whether or not the Practice Guideline should remain in effect. The MM/UM Committee's decision is documented in the MM/UM Committee meeting minutes and the website is either updated to reflect the most current version of the Practice Guideline or the Guideline is removed. T/RBHAs are notified of any changes to the DBHS adopted practice guidelines and disseminate this information to all affected providers and if appropriate, to recipients and potential recipients. 						

ADHS/DBHS 2012 Work Plan

Goals: 6. New Practice Guidelines will be adopted as clinically appropriate.

7. New Technologies and New Uses of Existing Technologies will be reviewed, discussed, and adopted as appropriate.

Area of Review/Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/Analysis of Intervention	Next Review	Comments	Results/Outcomes
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Goal # 7: New Technologies and New Uses of Existing Technologies will be reviewed, discussed, and adopted as appropriate.							
1. Evaluate New Medical Technologies and New Use of Existing Technologies, as appropriate.	ADHS/DBHS CMO will: <ul style="list-style-type: none"> Review and evaluate all RBHA requests for New Medical Technologies/New Use of Existing Technologies to determine whether the medical technology is: <ul style="list-style-type: none"> Applicable to the Behavioral Health Population Meets Medical Standards and has been approved by the FDA The request will meet Recipient need Share the RBHA's CMO's recommendations with the MM/UM Committee, as needed. 	MM/UM Office Chief ADHS/ DBHS CMO					

ADHS/DBHS 2012 Work Plan

Goals: 8. Monitor Contractors' care coordination activities to ensure they are clinically appropriate in meeting members' needs (evidenced by a score of 85 percent or Higher)

Area of Review/Objectives	Action to Be Taken/Intervention	Responsible Party	Progress Towards Goals	Evaluation/Analysis of Intervention	Next Review	Comments	Results/Outcomes
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Goal #8: Care Coordination/ Case Management							
1. Monitor the RBHAs' care coordination activities to ensure that care is coordinated as appropriate. RBHAs must meet or exceed 85 percent for this element.	Care Coordination is delegated to RBHAs; ADHS/DBHS will: <ul style="list-style-type: none"> Monitor RBHAs COC progress to ensure that they meet AHCCCS required MPS (minimum performance standard of 85 percent) on a quarterly basis. Select a 90/10 random sample of behavior health recipients (BHR) from DBHS/CIS data with an open episode of care during the first day of the quarter and require the RBHAs to evaluate care coordination practices with the Health Plans' PCPs by confirming that requests for information by the Health Plan or PCP was responded to timely. Conduct analysis of the data provided and compare it to the narrative summary provided by the Contractor. Track any decreases in performance and /or addressing any deficiencies by providing technical assistance or issuing a CAP. Validate the RBHA's findings during the Annual Administrative Review. Report results of the validation to the MM/UM and QM Committees on a quarterly basis. 	MM/UM Manager, OPI Manager					
2. Ensure consistent care coordination practices for the DDD (specialty) population.	The ADHS/DBHS MM/UM and OPI Manager will: <ul style="list-style-type: none"> Work with DDD to re-evaluate the sampling methodology for COC for DDD population. Work with the Contract Compliance department to amend the DDD contract language around report submission timelines. Report results to the MM/UM and QM Committees on a quarterly basis. Submit quarterly reports on COC activities to DDD 	MM/UM Manager, OPI Manager					



2012 Annual Quality Management Plan
(AHCCCS Contract Year October 1, 2011 – September 30, 2012)
(C-D-23, AMPM 910-A-1)

Kristy Benton, Office Chief
Office of Performance Improvement
Bureau of Quality Management Operations
Division of Behavioral Health Services

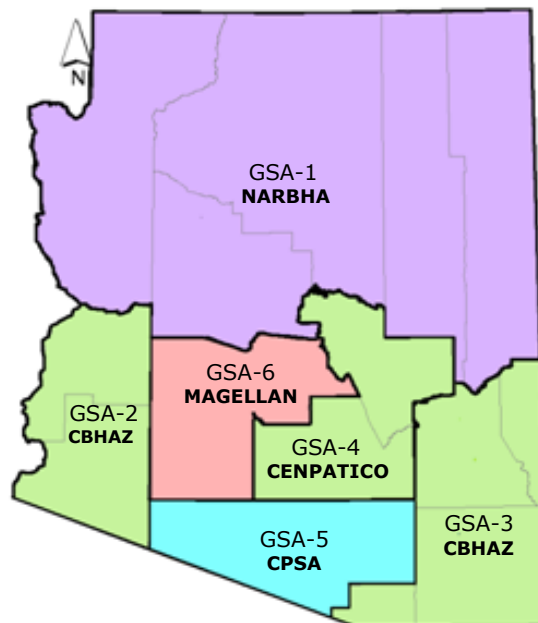
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I. Introduction

1. ADHS/DBHS System

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) serves as the single state authority that provides administration, regulation, and monitoring of all facets of the state publicly funded behavioral health system. ADHS/DBHS Contractors are community-based organizations known as Regional Behavioral Health Authorities (RBHAs) and Tribal Behavioral Health Authorities (TBHAs). ADHS/DBHS Contractors administer behavioral health services throughout the state and function in a fashion similar to health maintenance organizations. Contractors are responsible for the development of comprehensive service networks to provide a full continuum of behavioral health services for adults with substance abuse and general mental health disorders, adults with serious mental illness (SMI), and children.

The state is divided into six geographical service areas (GSAs) served by four Contractors:



- [Cenpatico Behavioral Health of Arizona](#) (CBHAZ) serves three GSAs (GSAs 2, 3 and 4) covering Pinal, Gila, Graham, Greenlee, Santa Cruz, Cochise, Yuma, and La Paz Counties.
- [Community Partnership of Southern Arizona](#) (CPSA) serves one GSA (GSA 5) covering Pima County.
- [Northern Arizona Behavioral Health Authority](#) (NARBHA) serves one GSA (GSA 1) covering Mohave, Coconino, Apache, Navajo, and Yavapai Counties.
- [Magellan of Arizona](#) (Magellan) of Arizona serves one GSA (GSA 6) covering Maricopa County.

In addition to these geographic service areas, ADHS/DBHS has Intergovernmental Agreements (IGAs) with three of Arizona's American Indian Tribes to deliver behavioral health services to persons living on the following reservations:

- [Gila River Indian Community](#)
- [Pascua Yaqui Tribe](#)
- [White Mountain Apache Tribe of Arizona](#)

2. Program Vision, Mission and Goals

ADHS/DBHS' vision for the delivery of quality behavioral health services provides the foundation for all Quality Management activities. The ADHS/DBHS vision states:

All Arizona residents touched by the public behavioral health system are easily able to access high quality prevention, support, rehabilitation and treatment services that have resiliency and recovery principles at their core, which assist them in achieving their unique goals for a desired quality of life in their homes and communities.

To support the ADHS/DBHS vision, the mission of the ADHS/DBHS BQMO is:

- Improve the quality of care provided to all behavioral health recipients;
- Improve behavioral health recipient satisfaction with services received; and
- Improve outcomes for all behavioral health recipients.

The 2012 ADHS/DBHS QM Plan is designed to achieve the goal of improved quality of care for behavioral health recipients utilizing evidenced-based practices, to meet or exceed AHCCCS requirements. Activities defined to support QM processes and program goals are delineated in the ADHS/DBHS QM Work Plan (Attachment A). These activities serve to direct and focus the ADHS/DBHS QM program and include clearly defined goals, measurable objectives, data feeds, responsible parties, frequencies of activities and target dates for activities completion

II. Scope of the QM Program

The ADHS/DBHS QM Plan includes all quality improvement activities conducted and managed by the Office of Performance Improvement (OPI) in BQMO, including the monitoring and oversight of Contractors' QM activities. ADHS/DBHS uses analysis of the behavioral health system's performance, feedback from behavioral health recipients and stakeholders, and evidence based practices to drive the performance improvement activities and new initiatives included in this Plan.

The ADHS/DBHS QM Plan includes monitoring reports and quality improvement activities pertaining to the following service categories and treatment settings:

Service Categories:

- Treatment Services
- Rehabilitation Services

- Medical Services
- Support Services
- Crisis Intervention Services
- Inpatient Services
- Residential Services
- Behavioral Health Day Programs

Treatment Settings:

- Level I Hospital
- Level I Psychiatric Hospital
- Level I Residential Treatment Center
- Level I Sub-acute Facility
- Level II Behavioral Health Residential
- Behavioral Health Outpatient Clinic
- Level III Behavioral Health Residential (non-IMD)
- Community Service Agency
- Behavioral Health Therapeutic Home
- Rural Substance Abuse Transitional Center
- Crisis Services Provider

Specific information regarding covered services and treatment settings can be found in the [ADHS/DBHS Covered Behavioral Health Services Guide](#).

Quarterly and Annual Evaluations

ADHS/DBHS conducts quarterly and annual evaluations of the Annual QM Work Plan (Attachments B and C) and reports the results to the QM Committee. Evaluation of progress toward meeting the QM Program goals is used to determine the scope of the coming year's activities and in the development of QM processes and performance improvement activities.

III. Quality Management Administrative Oversight

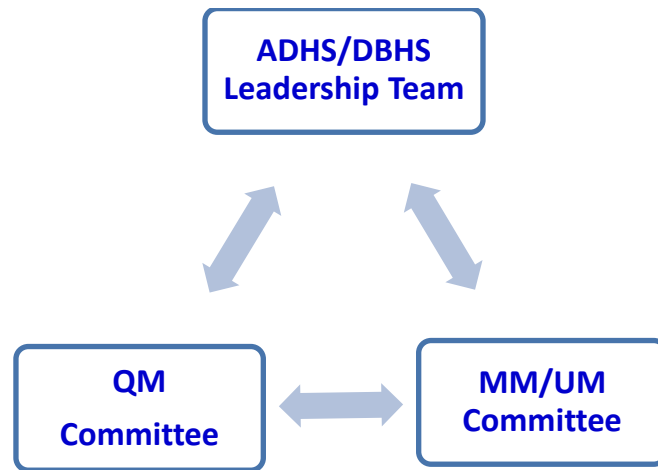
Structural Framework and Communication (C-D-23, AMPM 910-A-1-b)

The ADHS/DBHS Bureau of Quality Management Operations (BQMO) works collaboratively with all functional areas of ADHS/DBHS in the ongoing assessment and evaluation of the quality of services provided to behavioral health recipients. The ADHS/DBHS committees are utilized for decision making, performance monitoring, development of performance improvement activities, and as a means for incorporating stakeholder and member feedback into QM activities.

ADHS/DBHS Leadership Team

The ADHS/DBHS Leadership Team acts as the governing and policy making body for ADHS/DBHS. As seen in the diagram, the Leadership Team oversees the ADHS/DBHS QM program, providing strategic direction and ultimate authority for the scope of QM activities. The Leadership Team ensures ongoing communication between ADHS/DBHS QM and other ADHS/DBHS functional areas so that improvement activities are ongoing

and effective. As the diagram indicates, the Leadership Team is the final approval authority for all activities related to the ADHS/DBHS system of care.



Membership: Laura Nelson, M.D., Deputy Director, (**Chair**)
Robert Sorce, Assistant Director
Ann Froio, Assistant Director
Steven Dingle, M.D., Chief Medical Officer
Sara Salek, M.D., Deputy Chief Medical Officer
Cynthia Layne, Chief Financial Officer
Margery Ault, Branch Chief, Consumer Rights
Claudia Sloan MBA, Special Projects Administrator,

Meeting Frequency: Weekly

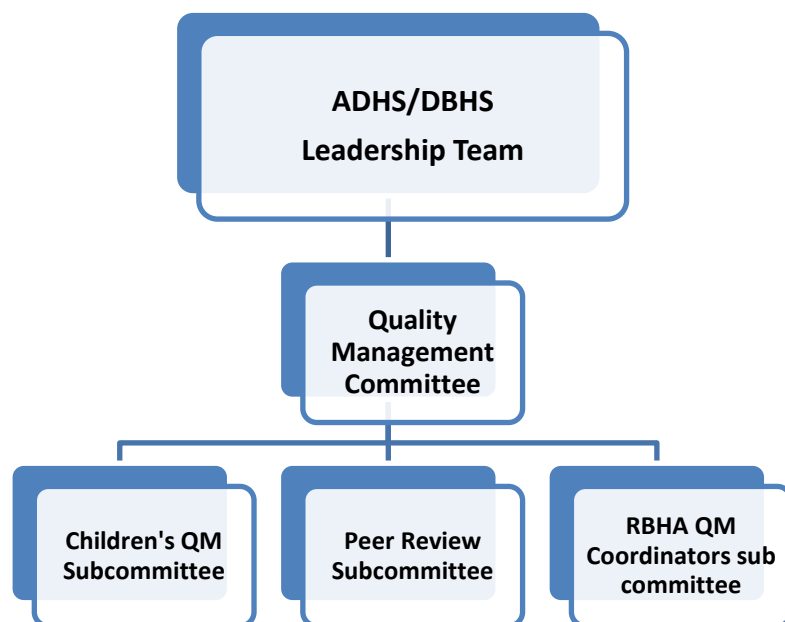
Quality Management Committee (ADHS/DBHS QM Committee)

(C-D-23, AMPM 910-C-1-a, AMPM 910-C-3-a-1-2-3-5, AMPM 920-C-1-b)

The QM Committee is chaired by the Chief Medical Officer (CMO) and co-chaired by the Manager of the Office of Performance Improvement (OPI) in the Bureau of Quality Management Operations (BQMO).

The ADHS/DBHS QM Committee ensures ongoing communication and collaboration between executive leadership and other functional areas of the Division and agency. Each ADHS/DBHS functional area is represented in the ADHS/DBHS QM Committee.

Committee members are informed of confidentiality and conflict of interest requirements related to serving on the committee. Sign-in sheets with confidentiality and conflict of interest language are completed at all meetings. The committee reviews, modifies, and updates QM program objectives, policies and procedures at least annually and completes quarterly status reviews of the QM Work Plan (C-D-17, C-D-23-A-1, C-D-23 6, 6-F, AMPM 910-C-3-b and e, AMPM 960-D-1-a).



Membership:

Voting Members

Steven Dingle, M.D., Chief Medical Officer (**Chair**)
Kristy Benton, Office Chief, OPI (**Co-Chair**)
Ashraf Lasee, Branch Chief, BQMO
Margery Ault, Branch Chief, Consumer Rights
Laura Nelson, M.D., Deputy Director
Sara Salek, M.D., Deputy Chief Medical Officer
Ann Froio, Assistant Director
Cynthia Layne, Chief Financial Officer
Margaret McLaughlin, Acting Branch Chief, Compliance
Melissa Thomas, Acting Branch Chief, Program Operations
Kathy Bashor, Office Chief, Office of Individual and Family Affairs

Non-Voting Members

Alexandra O'Hannon, Office Chief, Medical Management
Office Chief, BQMO Information Management
QM Staff: QOC RNs, Performance Measure RN/Specialist and PIP Coordinator

Meeting Frequency: Monthly

The ADHS/DBHS QM Committee receives feedback and recommendations for performance improvement activities from various subcommittees, work groups and other ADHS/DBHS functional areas. There are three subcommittees under the QM Committee:

1. The Children's QM Subcommittee
2. Peer Review Subcommittee
3. The QM T/RBHA Coordinators Subcommittee

The BQMO Medical Management/Utilization Management (MM/UM) Committee also provides semi-annual updates to the ADHS/DBHS QM Committee on MM/UM activities and makes recommendations to facilitate communication and coordination of improvement activities between QM and MM/UM programs.

Children's QM Subcommittee

The purpose of this subcommittee is to monitor quality management and improvement activities specific to children's services and improve practice according to the Arizona 12 Principles. This subcommittee reviews data that includes performance measures, member and family feedback, and outcome measures.

The Children's QM Subcommittee is chaired by the Deputy Chief Medical Officer and co-chaired by the Office Chief of the Office of Performance Improvement in the Bureau of Quality Management Operations (BQMO).

Subcommittee reports are presented quarterly to the ADHS/DBHS QM Committee to provide recommendations and clinical expertise into the development of specific measures for children.

Committee members are informed of confidentiality and conflict of interest requirements related to serving on the committee. Sign-in sheets with confidentiality and conflict of interest language are completed at all meetings.

Membership:

Sara Salek, M.D., Deputy Chief Medical Officer, (**Chair**)
Kristy Benton, Office Chief, OPI (**Co-Chair**)
Steven Dingle, M.D., Chief Medical Officer
Ashraf Lasee, Branch Chief, BQMO
Ann Froio, Assistant Director
Melissa Thomas, Acting Branch Chief, Program Operations
Kathy Bashor, Office Chief, Office of Individual and Family Affairs
Lou Ann Allard, Office Chief, Customer Service
Kimberly Engle, Office Chief, Children's System of Care
Kim Skrentny, Children's Clinical Advisor
Ronald Copeland, Implementation Manager, Children's System of Care
Steve Lazere, Implementation Manager, Children's System of Care
Kevin Flynn, Implementation Manager, Children's System of Care
Katie Jebraail, Implementation Manager, Children's System of Care
Robert Crouse, Implementation Manager, Children's System of Care

Meeting Frequency: Quarterly

Peer Review Committee

(C-D-23-6-e and AMPM 960-C-6, AMPM 910-C-4-(a-m))

The purpose of the ADHS/DBHS Peer Review Committee is to improve the quality of medical care provided to ADHS/DBHS behavioral health recipients and provide oversight and direction to the ADHS/DBHS Contractors in their peer review process.

Peer Review Committee activities include a review of cases where there is evidence of a quality deficiency in the care or service provided, or the omission of care or a service, by a person or entity that subcontracts with an ADHS/DBHS Contractor or Contractor's subcontractor to provide covered services directly to behavioral health recipients.

The ADHS/DBHS Peer Review Committee will examine selected RBHA peer review outcomes and information to monitor the RBHA peer review process. As the result of the review, the ADHS/DBHS Peer Review Committee will make recommendations to the RBHA Chief Medical Officer for further action, when indicated.

Cases for peer review are also identified through various ADHS/DBHS monitoring processes, including Quality of Care (QOC) concern reviews and incident, accident and death reviews. To guide these activities, ADHS/DBHS follows the Policy QM 2.6 Peer Review, Peer Review Desktop Protocol, and Peer Review Process (Attachment D).

The Peer Review Committee operates under the confidentiality protections afforded by state and federal law as follows:

[42 U.S.C. 1320c-9](#); [42 U.S.C. 11101 et seq.](#); [42 CFR 51.41 \(c\) \(4\)](#); [A.R.S §36-441](#); [A.R.S. §36-445](#); [A.R.S. §36-2401](#); [A.R.S. §36-2402](#); [A.R.S. §36-2403](#); [A.R.S. §36-2404](#); [A.R.S. §36-2917](#); [A.R.S. § 36-3407](#); [A.R.S. §41-1092\(3\)](#); [A.R.S. §8-542](#); [AHCCCS Medical Policy Manual \(AMPM\) 910\(A\) \(4\)](#); and [AHCCCS Medical Policy Manual, Chapter 900, Sections 910 & 960](#).

Membership¹:

Voting Members:

Steven Dingle, M.D., Chief Medical Officer, (**Chair**)
Kristy Benton, R.N., Office Chief, OPI (**Co-Chair**)
Sara Salek, M.D., Deputy Chief Medical Officer
Peer Review Coordinator, QOC RN, OPI
Internal and External Licensed Medical and/or Clinical Professionals

Non-voting members:

Laura Nelson, M.D., Deputy Director
Ashraf Lasee, Branch Chief, BQMO
Subject Matter Experts by Invitation Only

Meeting Frequency: Quarterly and *ad hoc* as needed.

¹ ADHS/DBHS uses external consultants when necessary specialty expertise is not available internally.

The T/RBHAs QM Coordinators Subcommittee Meeting

This subcommittee is chaired by the Office Chief of the Office of Performance Improvement and serves as the primary planning, policy and problem-solving communication channel between ADHS/DBHS Quality Management (QM) program and its Contractors. The main objective of the T/RBHAs QM Coordinators subcommittee is to disseminate ADHS/DBHS information, provide technical assistance, and receive feedback from the Contractors. The goal is to enhance ADHS/DBHS oversight of the Contractors' QM processes and activities, share QM data, incorporate ADHS/DBHS Contractors and their providers' input into the ADHS/DBHS QM system and improve Contractor compliance with QM contractual requirements.

Statewide quality management initiatives are discussed and technical assistance is provided by ADHS/DBHS. The meetings incorporate a roundtable discussion in which the Contractors can provide feedback to ADHS/DBHS QM and brainstorm best practices for incorporation into QM activities. In addition to quarterly meetings, ADHS/DBHS may call *ad hoc* meetings with Contractors to review new or revised QM requirements, report performance measures specifications, discuss the QM Plan and Work Plan, etc.

Membership:

Kristy Benton, R.N., Office Chief, OPI, (**Chair**)
Ashraf Lasee, Branch Chief, BQMO
BQMO Performance Improvement Specialists
Alexandra O'Hannon, Office Chief, Office of Medical Management
Office Chief (vacant) Office of Information Management
RBHAs Quality Management (QM) Coordinators/Directors

Meeting Frequency: Quarterly

ADHS/DBHS QM Staffing Description

The ADHS/DBHS BQMO's Office of Performance Improvement (OPI) has general responsibility for the ADHS/DBHS Quality Management functions. ADHS/DBHS OPI is staffed with individuals who have the knowledge and experience to perform QM activities within each function/performance area: Quality of Care (QOC) Concerns, Performance Measure tracking, monitoring and oversight, Performance Improvement Project (PIP), ADHS/DBHS Annual Consumer Survey, and other programmatic and administrative activities.

BQMO/OPI Staff Job Descriptions

Chief Medical Officer - Steven Dingle, M.D.: is the ADHS/DBHS Chief Medical Officer (CMO); who is an Arizona-licensed physician (Psychiatrist). The CMO is responsible for:

- Chairing the ADHS/DBHS Quality Management Committee and the Peer Review Subcommittee
- Providing clinical oversight of the Quality of Care (QOC) process

- Working with RBHA Chief Medical Officers on issues related to QOC and Peer Review
- Providing direction and input into ADHS/DBHS Performance Improvement Projects

Branch Chief, Bureau of Consumer Rights - Margery Ault, J.D.: The ADHS/DBHS Branch Chief for the Bureau of Consumer Rights reports to the ADHS/DBHS Deputy Director. The Branch Chief (Consumer Rights):

- Provides administrative, executive-level leadership, guidance and support for BQMO as well as the Offices of Human Rights, Grievance and Appeals and Customer Service.
- Serves as a member of ADHS/DBHS' Leadership Team

Branch Chief, BQMO - Ashraf Lasee, M.B.B.S, M.P.H., Dr. P.H.: The Branch Chief for the Bureau of Quality Management Operation is responsible to ensure ongoing communication and collaboration between executive leadership, BQMO, and other functional areas of the Division of Behavioral Health Services; provides administrative support and technical assistance to three Offices in the Bureau: Office of Performance Improvement (OPI), Office of Medical and Utilization Management (MM/UM), and the Office of Information Management; and provides leadership to communicate program related issues and needs with AHCCCS. On a daily basis, the Branch Chief is responsible for:

- Focusing organizational efforts on improving clinical quality performance measures
- Developing and implementing performance improvement projects
- Utilizing data to develop intervention strategies to improve outcomes
- Reporting quality improvement and performance outcomes
- Managing the BQMO which includes the Offices of Performance Improvement and Medical Management/Utilization Management
- Ensuring compliance with the Arizona Health Care Cost Containment System; (AHCCCS) Medical Provider Manual (AMPM) Chapter 900 (Quality Management) and Chapter 1000 (Utilization Management)
- Monitoring AHCCCS Performance Measures, including: access to care, coordination of care, behavioral health service plan and behavioral health service provision; consumer satisfaction; and others by all contractors and tribal partners to improve performance

Office Chief, Office of Performance Improvement (OPI) - Kristy Benton, R.N., B.S.N., M.P.H.: The Office Chief for the Office of Performance Improvement reports to the Branch Chief for the BQMO. The Office Chief is responsible for:

- Managing a team of eight OPI staff
- Overseeing the day-to-day operations of the OPI
- Ensuring OPI's and its Contractors' compliance with AMPM 900
- Providing direct supervision to the Quality of Care Process and related issues
- Co-Chairing QM Committee with ADHS/DBHS Chief Medical Officer

- Coordinating performance improvement activities with AHCCCS, ADHS/DBHS contractors, tribal partners, consumers and family members, and other stakeholders and workgroups
- Providing technical assistance regarding ADHS/DBHS requirements, processes and operational matters to ADHS/DBHS contractors and tribal partners
- Overseeing and facilitating the Administrative Review Process of T/RBHAs in the quality management area
- Coordinating the QM components of AHCCCS' Operational and Financial Review process for ADHS/DBHS
- Overseeing and facilitating the bi-annual data validation activities
- Writing, revising and updating QM area policies and procedures for both internal and external use

QOC Program Lead - Linda Ellen Holmes M.B.A, ADN: The QOC Lead is responsible for:

- Coordinating the procedural and substantive QOC activities of all staff conducting QOC reviews
- Reviewing all Incident, Accident, and Death (IAD) reports submitted by RBHAs and other sources on a regular basis; conducting and monitoring inter rater reliability checks among reviewers on a weekly basis
- Tracking and trending QOCs; developing weekly and quarterly QOC tracking reports
- Monitoring and evaluating quality of care data to determine any trends related to quality of care in ADHS/DBHS' systems of care
- Coordinating the Peer Review subcommittee with DBHS Chief Medical Officer
- Coordinating Peer Review related activities with Contractors' CMOs
- Ensuring compliance with federal, state, and contractual requirements

QOC Program Staff - Earlene Allen, R.N., M.C. (Masters in Counseling), Michele Reese, R.N. (starts 12/26/2011) and a QOC Analyst: The QOC Program staff job responsibilities include, but are not limited to:

- Reviewing Incident, Accident and Death (IAD) reports and identifying potential QOC concerns
- Receiving and reviewing potential QOC concerns from ADHS/DBHS staff and outside agencies
- Communicating these potential concerns with Contractor QOC personnel
- Assessing and evaluating the care provided to individuals receiving services based on the results of QOC investigations
- Monitoring and evaluating level and quality of care to improve services, and
- Appraising and assessing whether existing services are meeting the needs of individuals receiving services in the community

Performance Improvement Project (PIP) Coordinator - Jennifer Tonges, B.A. Psychology: PIP coordinator's responsibilities include, but are not limited to:

- Coordinating the development, design and implementation of PIP projects
- Developing PIP project proposals and updates to current PIPs
- Assisting other OPI staff as needed

Performance Measure Program Lead - (Grade 22 RN position-Interviews in process): The Performance Program Lead will report to the Office Chief, OPI. The responsibilities include, but are not limited to:

- Coordinating the work of two performance improvement staff
- Organizing and directing Annual Administrative Reviews and ongoing data validation activities in the area of performance measures, credentialing and the Medical Record Review
- Developing annual performance improvement reports and correspondence
- Providing feedback and technical assistance as necessary to ADHS/DBHS Contractors and tribal partners on performance measures, reports, and OPI policies and procedures
- Addressing the core business functions of OPI as described in the annual QM Plan
- Attending meetings internally and externally on quality improvement and OPI administration topics

Performance Measure Program Staff - (Patricia Valez and two vacant positions which are in the hiring process): The Performance Measure Staff responsibilities include, but are not limited to:

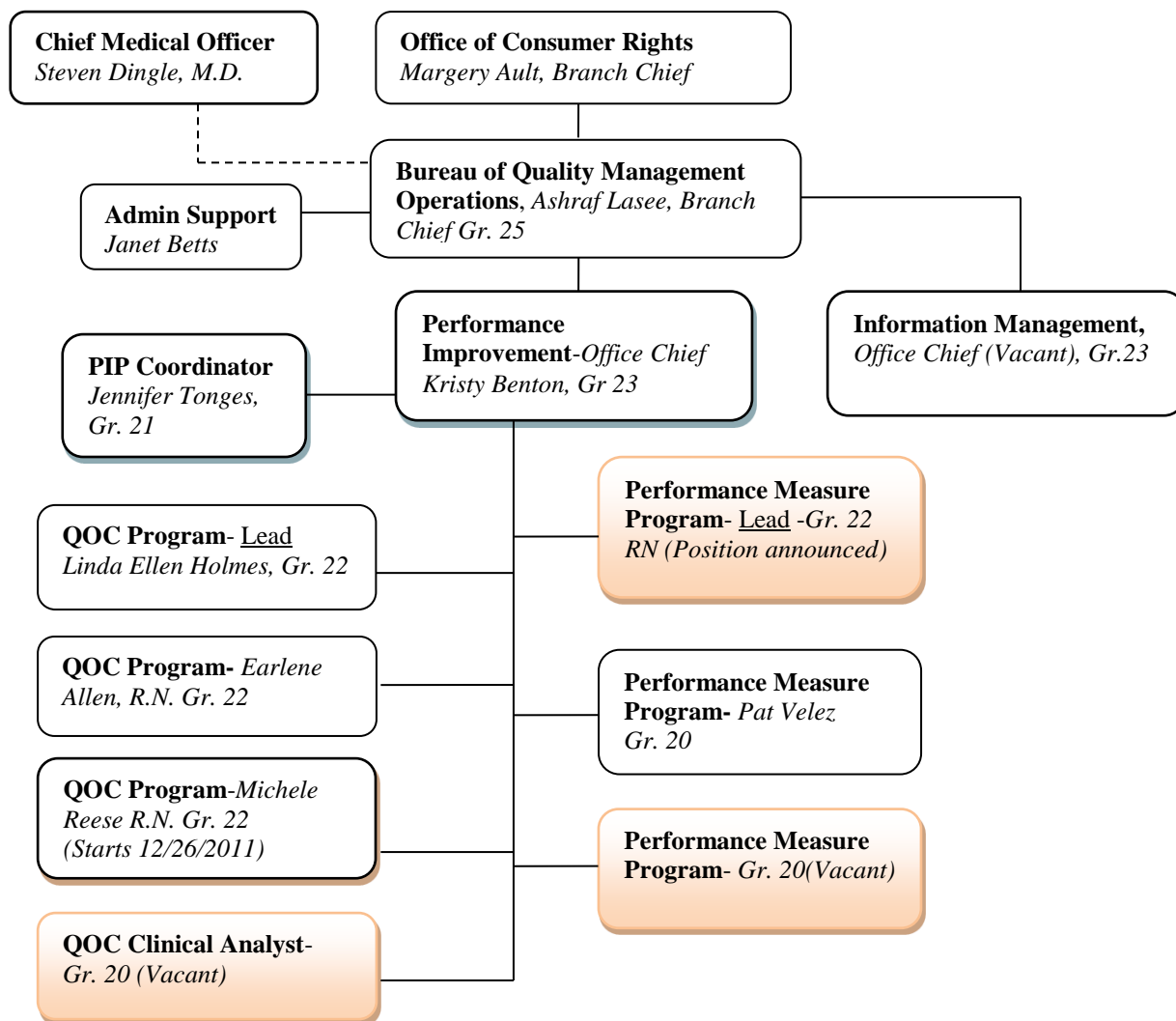
- Participating in the development and execution of performance improvement activities based on data analysis and AHCCCS requirements
- Completing quarterly reviews and analyzing contractors' performance related to specific performance measures
- Conducting semi-annual data validation activities and monitoring of corrective action plan(s) submitted by the ADHS/DBHS Contractors
- Completing *ad hoc* and focused reviews, as required by the Chief of the Office of Performance Improvement
- Providing technical assistance to Contractors regarding performance improvement activities
- Addressing core business functions of OPI as described in the annual QM Plan

Office of Information Management: The Information Management (IM) Office Chief works with a team of three full time staff (Carolyn Dempsey, Vanessa Cardenas and Rahnuma Khandaker) and a part time consultant (Julie Karcis, NP, M.P.H). The OIM staff assist with quality and utilization management data needs in the BQMO as follows:

- Tracking incoming and outgoing QM and MM/UM Deliverables
- Assisting OPI in data analysis for the ADHS/DBHS Annual Consumer survey, AHCCCS Enrollee Grievance Report (Complaint Resolution Summary), Performance Measure evaluation and improvement activities, developing visual presentations for the QM Committee meetings
- Developing utilization reports on SMI eligibility determinations, length of stay (LOS), re-admission rates, RBHA prior authorizations, and pharmacy utilization for provider monitoring and oversight, and evaluating Contractors' compliance

- Developing At-a-Glance Charts and Graphs for Performance Measures, Complaints, Quality of Care trending and Utilization Management measures
- Monitoring and updating the ADHS/DBHS Outcomes Dashboard
- Developing ADHS/DBHS-BQMO Specification manual – a manual for ADHS/DBHS and T/RBHA staff describing how to generate QM and MM/UM area data and reports per AHCCCS Requirements (Attachment K)
- Assisting ADHS/DBHS Finance and Contract Compliance Bureaus for Annual Performance Incentives calculation and evaluation

Office of Performance Improvement - Org Chart



Collaboration with other ADHS/DBHS Functional Areas:

In addition to the functional areas within the BQMO, another ADHS/DBHS organizational area plays a significant role in supporting BQMO operations. The Bureau of Business Information within ADHS/DBHS supports the integrity of Client Information System through publications such as the Demographics Users Guide (DUG) and the Operations and Procedures Manual, which provide guidelines to data reporting structures for claims and demographic data. Both Offices also implement data integrity processes such as audits and data checks on contractor-submitted data.

IV. Quality Management Plan Activities

(C-D-17, C-D-23-A-1, AMPM 910-C-3-e, AMPM 920-B-2)

This section describes all ADHS/DBHS (internal) and Contractor (external) quality improvement activities and processes. ADHS/DBHS mandates that all Contractors incorporate ADHS/DBHS' quality improvement activities into their QM Plans.

Monitoring and Evaluation Activities (C-D-23-B-II, AMPM 920-B-3, AMPM 940-2-b-c)

ADHS/DBHS QM conducts monitoring and evaluation of QM activities through monthly and quarterly direct data reports from its Contractors, focused *ad hoc* reviews and annual administrative reviews. The following are descriptions of all ADHS/DBHS QM activities.

Data Integrity Activities (C-D-38, AMPM 910-A-1-q, BBA-488.242(b)(3))

Accurate and reliable data is imperative for the success of the ADHS/DBHS QM program. Per Provider Manual Section 7.5, Enrollment, Disenrollment and Other Data Submissions (Attachment F), Contractors are required to maintain a health information system which includes data elements such as member demographics, service utilization, provider characteristics, episode of care status, outcomes measures and diagnoses for use in ADHS/DBHS and Contractor QM activities.

Data submitted to the ADHS/DBHS Client Information System (CIS) must pass a series of validation measures and logic safeguards prior to acceptance. Each validation measure or edit is designed to operate in a specific manner to ensure accuracy, completeness and logic. ADHS/DBHS provides direction related to systems edits and business rules to its Contractors through the [Demographic and Outcome Data Set Users Guide \(DUG\)](#).

To improve the quality of data submitted directly to ADHS/DBHS QM for performance monitoring and evaluation, ADHS/DBHS developed the BQMO Specifications Manual (Attachment K) which includes details on the ADHS/DBHS methodologies for calculating and reporting all performance indicators. ADHS/DBHS mandates that Contractors use standardized report templates and methodologies as outlined in the BQMO Specifications Manual in their QM reporting. The standardization of reporting ensures consistency in collection and reporting of critical data elements across Contractors for improved analysis on a statewide level.

ADHS/DBHS quality of care (QOC) and performance measure staff participate in inter-rater reliability (IRR) exercises regularly to ensure consistency in staff interpretation of review questions and documentation ratings, thereby increasing the reliability of the review process. ADHS/DBHS BQMO conducts data validation activities twice a year to support the integrity of data reported by its Contractors. Contractors failing to meet the minimum performance standards are required to submit corrective action plans.

ADHS/DBHS-BQMO Review Activities

Annual Administrative Review

The Bureau of Quality Management Operation staff conducts annual comprehensive operational and financial reviews of each Contractor to assess compliance with contractual requirements and quality management standards and perform data validation activities. ADHS/DBHS establishes scoring criteria for each indicator reviewed. Contractors falling below performance expectations are required to develop corrective action plans (CAP) that reflect interventions to improve future performance. Contractor CAPs are monitored and tracked by the ADHS/DBHS Bureaus of Quality Management and Compliance, and the status of each CAP is reported quarterly to the ADHS/DBHS QM Committee.

ADHS/DBHS conducted its 2011 Annual Administrative Review during October and November of 2011 according to the following schedule:

- Magellan 10/11/2011 - 10/13/2011
- CPSA 10/18/2011 - 10/20/2011
- NARBHA 10/25/2011 - 10/27/2011
- Cenpatico 11/02/2011 - 11/04/2011
- Gila River, Pascua Yaqui and White Mountain desk review – Nov-Dec, 2011

The Administrative Review *Schedule* and the *Tool* were developed and shared with AHCCCS for feedback and Comments.

At the end of each RBHA Administrative Review, an Exit Interview was conducted with RBHA staff for preliminary feedback and a performance update; and also to provide them an opportunity to submit additional documentation to demonstrate their performance.

Administrative Review scores for each standard are in the process of being finalized; final reports will be shared with RBHAs to assist them in developing corrective action plans.

Data Validation Reviews

ADHS/DBHS OPI conducts biannual on site data validation activities to ensure the accuracy of data used to evaluate Contractor performance in QM area. Data validation findings are reported to the ADHS/DBHS QM Committee. Discrepancies in Contractor reported data and the data validation review findings are addressed through targeted

technical assistance, performance improvement plans and further corrective actions as needed.

Incident/Accident and Death (IAD) Report Reviews

ADHS/DBHS requires its Contractors to report incidents, accidents and deaths per Policy QM 2.5 (Reports of Incident, Accident, and Death), and Provider Manual Section 7.4 (Reporting of Incident, Accident and Death), and as outlined in ADHS/DBHS BQMO Specifications Manual. Contractors are required to report significant and/or adverse incidents for all enrolled behavioral health recipients. These incidents are reported to ADHS/DBHS within one day of the notification to the Contractors.

The Contractors are required to electronically submit to the ADHS/DBHS all mortalities, incidents of sexual and physical abuse, morbidities that require medical intervention, incidents of absence without leave (AWOL) from Level I facilities, medication errors that result in adverse outcomes, and human rights related violations etc.

ADHS/DBHS QOC staff review Incident, Accident and Death (IAD) reports and identify potential QOC concerns. Inter Rater Reliability (IRR) checks are conducted on a weekly basis for a select sample of cases to ensure consistency in reviewers' findings. These potential QOC concerns are communicated with respective Contractor QOC personnel for investigation. Contractor data is aggregated on a statewide level and presented to the QM Committee.

QOC concerns can also be referred to ADHS/DBHS Peer Review subcommittee for further review and recommendation. QOC and Peer Review activities are protected under the following Arizona Revised Statute (A.R.S.) and federal protections:

[42 U.S.C. 1320c-9](#); [42 U.S.C. 11101 et seq.](#); [42 CFR 51.41 \(c\) \(4\)](#); [A.R.S. §36-441](#)-[A.R.S. §36-445](#); [A.R.S. §36-2401](#); [A.R.S. §36-2402](#); [A.R.S. §36-2403](#); [A.R.S. §36-2404](#); [A.R.S. §36-2917](#); [A.R.S. § 36-3407](#); [A.R.S. §41-1092\(3\)](#); [A.R.S. §8-542 AHCCCS Medical Policy Manual \(AMPM\) 910\(A\) \(4\)](#); and [AHCCCS Medical Policy Manual, Chapter 900, Sections 910 & 960](#).

Peer Review (C-D-23-6-e and AMPM 960-C-6)

ADHS/DBHS conducts peer reviews at least quarterly within the Peer Review Committee. The purpose is to improve the quality of care provided to behavioral health recipients. The Peer Review Committee selects and reviews cases where there is evidence of inadequate and/or substandard care; inappropriate utilization of services, which includes a quality deficiency or omission of a service; and adverse outcomes, including morbidities and mortalities. The Committee may also review Contractor's Quality of Care (QOC) and non-QOC complaints.

ADHS/DBHS requires all Contractors to conduct Peer Reviews in accordance with the AMPM Chapter 900, and ADHS/DBHS Policy QM 2.6 (Peer Review Policy) (included in Attachment D).

ADHS/DBHS monitors Contractor peer review activities biannually through the ADHS/DBHS data validation and Administrative Review; and quarterly within the Peer

Review Committee. The Peer Review Committee operates under A.R.S. and federal protections:

[42 U.S.C. 1320c-9](#); [42 U.S.C. 11101 et seq.](#); [42 CFR 51.41 \(c\) \(4\)](#); [A.R.S. §36-441-A.R.S. §36-445](#); [A.R.S. §36-2401](#); [A.R.S. §36-2402](#); [A.R.S. §36-2403](#); [A.R.S. §36-2404](#); [A.R.S. §36-2917](#); [A.R.S. § 36-3407](#); [A.R.S. §41-1092\(3\)](#); [A.R.S. §8-542 AHCCCS Medical Policy Manual \(AMPM\) 910\(A\) \(4\)](#); and [AHCCCS Medical Policy Manual, Chapter 900, Sections 910 & 960](#).

Provider Monitoring

ADHS/DBHS requires Contractors to conduct on-site provider monitoring for all subcontractors at least annually; more frequent provider monitoring may take place for subcontractors demonstrating performance below minimum standards and as data evaluation indicates. Contractors are required to develop a mechanism for a focused review of provider sites as identified through trended data. As part of their provider monitoring, Contractors are required to implement processes for verifying the accuracy and timeliness of reported data, inter-rater reliability exercises, and the standardized collection of service information. Contractors must utilize provider monitoring data to implement performance improvement activities that are data driven, outcomes focused and systemic in scope to improve the quality of services provided to their members. Contractors include detailed provider monitoring plans in their Annual QM Plans, including a schedule and frequency of provider monitoring activities and provider monitoring tools. ADHS/DBHS oversees Contractor provider reviewing and approval of its Contractors' processes for meeting these requirements during biannual site visits.

Provider Profiling

ADHS/DBHS requires its Contractors to complete Provider Profiling quarterly as part of the provider monitoring process. Minimum provider profiling data elements must include ADHS/DBHS performance measures, complaints, grievance and appeals data, and ADHS/DBHS MM/UM measures.

ADHS/DBHS Contractors are required to develop a Provider Profile for each subcontractor by provider and/or service site and take corrective action to address deficiencies identified through trended data. Profiling data is used to improve recipient outcomes, support quality practice, and in the development of performance improvement activities to affect positive change for the Contractor, its providers, the service site, and the members' quality of care.

ADHS/DBHS Contractor's Provider Profiles are available for review in Contractor Dash Board reports located on each Contractor website.

ADHS/DBHS conducts Contractor Profiling activities quarterly through the synthesis of Contractor performance, utilization, compliance and review data. ADHS/DBHS presents these data across Contractors in various ADHS/DBHS committees and in reports to AHCCCS that are available to stakeholders and members for review at the [ADHS/DBHS website](#). ADHS/DBHS also utilizes Contractor profiling data for focused reviews, in the

development of Performance Improvement Projects (PIPs) and in the Request for Proposal (RFP) process.

Consumer Surveys (C-D-23, AMPM 910-A-1-n, BBA 438.202 (b))

ADHS/DBHS Bureau of Quality Management Operations conducts two annual consumer surveys: (1) Adult Consumer Survey, and (2) Youth Survey, based on the Substance Abuse and Mental Health Administration (SAMHSA) Mental Health Statistics Improvement Program (MHSIP) surveys.

The surveys request independent feedback from Title XIX/XXI adults and families of youth receiving services through Arizona's publicly funded behavioral health system. The surveys measure consumers' perceptions of behavioral health services in relation to the following domains:

- General Satisfaction
- Access to Services
- Service Quality/Appropriateness
- Participation in Treatment Planning
- Outcomes
- Cultural Sensitivity
- Improved Functioning
- Social Connectedness

ADHS/DBHS BQMO presents Consumer Survey data in the ADHS/DBHS Quality Management (QM) Committee. Contractor performance on outcome domains is used to measure the RBHA's eligibility for a financial incentive. Additionally, member satisfaction with *Access to Service* and *Participating in Treatment Planning* are two main indicators in the ADHS/DBHS Outcomes Framework and Dashboard.

ADHS/DBHS compiles statewide survey data into an annual deliverable reported to AHCCCS, submits survey data to SAMHSA's MHSIP, and publishes it on the ADHS/DBHS website (FY2011 Consumer survey submitted to AHCCCS on 12/15/11).

Coordination of Care (COC) (C-D-12, AMPM 910-A-1-p)

ADHS/DBHS is committed to improving the coordination and communication of member care between the behavioral health system and members' AHCCCS Primary Care Physicians (PCPs) and/or their AHCCCS Health Plan Coordinators. At a minimum, 85 percent of member files reviewed must contain appropriate documentation of communication with the member's primary care physician. Any Contractor falling below the *minimum performance standard* (MPS) is subject to corrective action and must develop a corrective action plan identifying interventions to improve and sustain compliance.

The ADHS/DBHS definition of COC is included in QM Plan Section XI (*Performance Measures*); the methodology for calculating the COC performance measure is explained in the ADHS/DBHS BQMO Specifications Manual (Attachment K). Policies and provider manual sections that support the ADHS/DBHS COC performance measures

include ADHS/DBHS Provider Manual 3.3 (Referral and Intake Process) and Provider Manual Section 4.3-*Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers* (Attachment F).

Outcomes Dashboard

All ADHS/DBHS QM processes and activities are designed to foster positive clinical and social outcomes for behavioral health recipients. In FY 2011, ADHS/DBHS implemented an outcomes framework that assesses the impact of ADHS/DBHS programs and initiatives on behavioral health outcomes. Primary indicators are defined using Client Information System (National Outcome Measures [NOMS]), the ADHS/BHS Annual Consumer Survey, QM performance measures data, MM/UM data, and network analyses.

The framework organizes these priority indicators into the four following categories, which are reported in a series of scorecards that collectively form the Outcomes Dashboard:

1. Access;
2. Service Delivery;
3. Coordination/Collaboration; and
4. Outcomes.

Statewide	
Outcomes: Individuals ...	Has quality of life improved for individuals served by the behavioral health system?
With a drug/alcohol use history are now abstaining	30.8%
Are not homeless	97.5%
Are employed	14.2%
Attend school	36.4%
Have no recent criminal justice system involvement	93.7%
Participate in self-help groups	Coming in 2012

The Dashboard is published on the ADHS/DBHS website for review by the public, contractors, providers and consumers: <http://www.azdhs.gov/bhs/dashboard/index.htm>

The Dashboard QM outcomes measures are developed by the BQMO Office of Information Management (OIM) and presented in the Quality Management Committee for review and approval. Outcomes Dashboard data are often discussed in the Leadership Team to assess the effectiveness of the System; develop strategic direction and recommendations, and to monitor Contractor progress on score cards.

Actions for Improvement (C-D-23-A-6-e, AMPM 920-C-1-a-b-c-6, AMPM 920-C-1-d)

ADHS/DBHS uses technical assistance and, where necessary, corrective action or other contractual remedies to correct the actions of Contractors exhibiting low performance on any of the AHCCCS or ADHS/DBHS performance indicators. ADHS/DBHS Contractors are required to incorporate the PDSA (Plan, Do, Study, Act) Model for continuous quality improvement in Corrective Action Plans (CAPs). CAPs must include: (1) measurable goals and objectives, (2) interventions, activities and tasks, (3) responsible parties, and (4) start and completion dates for each activity and task identified in the submitted CAP. The Contractors must include systemic interventions that include, but are

not limited to, training, policy review and revision, technical assistance and focused reviews. Contractor CAPs must utilize evidence-based practices in the reported interventions to meet and/or exceed performance expectations.

ADHS/DBHS BQMO approves and monitors all Contractor CAPs and mandates that Contractors report CAP performance quarterly. ADHS/DBHS BQMO reports the status of statewide QM CAPs to the QM Committee; the Contractor specific improvement plans are also presented within the ADHS/DBHS Compliance meetings. The ADHS/DBHS Leadership Team is the ultimate decision making body for approving CAP compliance and directing the levying of further corrective actions, including contractual remedies such as sanctions or notices to cure, as indicated. (C-D-23, AMPM 920-C-1-e)

QM Policy Development or Revision (C-D-17, AMPM 940-A-1-o)

The ADHS/DBHS Policy Committee has developed a schedule and protocol to monitor the revision of division-wide policies and procedures based on the AHCCCS-ADHS/DBHS Contract, and program requirements. Policies are revised at least annually or as necessary. All revised policies are presented in the QM Committee meeting for feedback and preliminary approval, and approved policies are then presented to ADHS/DBHS Policy Committee for justification of revisions. Policies are then sent out for Public Comments; after reviewing public comments, policies are revised if needed. Final policies are again presented to the QM Committee for final approval. Attachment F contains all QM policies.

V. Delegated Functions

(C-D-23, C-D-23-A-5, AMPM 910-A-1-h, AMPM 950-B-3)

ADHS/DBHS delegates the following QM functions to its Contractors as delineated in the ADHS/DBHS/RBHA contracts:

- A comprehensive QM program that includes all the required components within the ADHS/DBHS QM Plan, the AHCCCS AMPM Chapter 900, Policy 910 and the ADHS/DBHS/RBHA Contracts
- QI Committee
- Quality of Care concerns reporting and investigation
- Tracking and Trending of Member Complaints, Grievances, and Appeals
- Developing and Disseminating Member Handbooks
- Medical Record Maintenance
- Credentialing, Re-credentialing, Organizational credentialing and Provisional credentialing of all sub-contracted providers
- Provider Monitoring and Profiling

ADHS/DBHS provides oversight and retains ultimate accountability for all functions delegated to its Contractors (C-D-23, AMPM 910-C-6-e). Contractor quarterly and *ad hoc* reports, focused reviews, data validation site visits, and the Annual Administrative Review serve as the mechanisms by which ADHS/DBHS monitors delegated functions. Furthermore, the Contractors must do the following for activities they delegate to their providers:

- Execute a written agreement specifying the delegated activities and reporting responsibilities of the entity, including providing for revocation of the delegation or other remedies for inadequate performance

- Evaluate the entity's ability to perform the delegated activities prior to delegation
- Conduct ongoing monitoring of performance and the quality of services provided
- Annually review the delegated entity's performance
- Maintain, for ADHS/DBHS' review, evaluation reports and CAPs, as necessary, to ensure quality for all delegated activities

VI. Member Rights and Responsibilities

The ADHS/DBHS Contractor Member Handbooks are designed to provide behavioral health recipients and potential enrollees with information about services provided in the ADHS/DBHS system of care and information on member rights and responsibilities, including the complaint and grievance system requirements and the means to resolve issues outside of the Contractor's specific processes (such as ADHS/DBHS Customer Service).

Contractors must provide each member with a Handbook within 10 days of the member's first service. ADHS/DBHS utilizes the Administrative Review to monitor Contractor compliance with this policy and procedure. Handbooks must be easily accessible by all behavioral health recipients and potential enrollees. Members have the right to receive a Handbook at least annually.

The ADHS/DBHS Provider Manual Section 3.6 (Member Handbooks-Attachment F) delineates the mandatory components for each Contractor Member Handbook and is approved by AHCCCS before dissemination of these requirements to ADHS/DBHS Contractors. ADHS/DBHS provides the Contractors with the Handbook template and no revisions to the Handbooks may be made without prior approval by ADHS/DBHS.

VII. Medical Records and Communications

(C-D-17, C-D-21, C-D-23-A-3, AMPM 940-2-a, AMPM 940-3-a)

Contractors must ensure effective and continuous patient care through medical record documentation of each member's health status, changes in health status, health care needs and services provided. [ADHS/DBHS Provider Manual Section 4.2, Behavioral Health Medical Record Standards](#) (Attachment F) establishes *minimum required elements* for member medical records, including processes for the use of digital (electronic) signatures when electronic documents are utilized.

ADHS/DBHS utilizes the ADHS/DBHS Behavioral Health Service Provision Tool and the Medical Record Review Tool (Attachment L) to review Contractor medical records. ADHS/DBHS ensures all Contractors' QM programs comply with the required elements of Provider Manual Section 4.2 (the Behavioral Health Service Provision Tool, and the Medical Record Review Tool) through review of Contractor QM Plans.

ADHS/DBHS conducts quality reviews of Contractor medical records to assess compliance with ADHS/DBHS minimum required elements for Medical Record through *ad hoc* data validation site visits, quarterly record reviews for performance measures, and during the Annual Administrative Review. Identified deficiencies result in technical assistance and CAPs, and are monitored until improvement is sustained.

ADHS/DBHS ensures that each behavioral health recipient is guaranteed the right to request and receive a copy of their medical record; and to request that the record be amended or corrected, per Provider Manual Section 4.2.7-C (Attachment F) and as specified in *45 C.F.R. Part 164*.

To protect the confidentiality of behavioral health recipient medical information and ensure compliance with HIPAA requirements, ADHS/DBHS utilizes Policy and Procedure Manual Section CO 1.4 (Confidentiality), and Provider Manual Section 4.1 (Disclosure of Behavioral Health Information-Attachment F). All ADHS/DBHS Contractors and their sub-contractors must adhere to the requirements pertaining to the release of protected, confidential health information as mandated within these guidance documents.

VIII. Credentialing and Re-Credentialing Processes

(C-D-17, C-D- 23, C-D-23-A-5-a, C-D-23-6, AMPM 910-C, AMPM 950-B, AMPM 950-D, AMPM 950-F-1-b-4, AMPM 960-A)

ADHS/DBHS delegates organizational and provider credentialing to its Contractors (including temporary credentialing, initial credentialing, and re-credentialing). ADHS/DBHS requires Contractors to develop and implement credentialing policies, procedures and protocols that meet AHCCCS and ADHS/DBHS requirements. Contractors must utilize the Contractor Credentialing Committee, Peer Review Committee or similar body to oversee credentialing and re-credentialing decisions. The Contractor's Medical Director or other designated physician is responsible for oversight of the credentialing process. Contractors and subcontractors must utilize participating Arizona Medicaid network providers in making credentialing decisions.

Contractors must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process. Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-alike Center, as well as hospital employed physicians (when appropriate), must be credentialed using the temporary or provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional.

Contractors shall have 14 days from receipt of a complete application within which to render a decision regarding temporary or provisional credentialing. ADHS/DBHS provides oversight, monitoring and technical assistance when needed. Contractors' credentialing processes and files (a random sample of 30 files for each type of credentialing: temporary, initial, and re-credentialing) are reviewed during the ADHS/DBHS Annual Administrative Review to ensure that providers are appropriately credentialed.

Credentialing processes must include records of onsite inspections of non-licensed providers to ensure compliance with credentialing requirements. The credentialing process must include a mechanism for providers to appeal credentialing decisions.

Contractors must appropriately re-credential their subcontracted providers every three years.

ADHS/DBHS mandates that Contractors utilize the ADHS/DBHS Credentialing and Re-credentialing Tools (Attachment E) for all credentialing activities for all provider types. Provider Manual Policy Section 3.20, Credentialing and Recredentialing (Attachment F) includes the Contractors' requirements for this function.

IX. Tracking and Trending of Member and Provider Issues

(C-D-17, C-D-23 A-3, C-d-23-6-a, b and d, AMPM 960 B-1-2-a thru d, AMPM 960 B-3 thru 7, BBA 438.420 (a) (b) (3))

Non-Quality of Care (Complaints, Appeals and Grievances)

ADHS/DBHS defines the issues captured in the non-quality of care process in the following ADHS/DBHS Policies, Procedures and Provider Manual sections:

- Policy GA 3.6 Complaint Resolution
- Provider Manual Section 5.2 Member Complaints
- Provider Manual Section 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
- Policy G.A. 3.3 Title XIX/XXI Notice and Appeal Requirements
- Policy GA 3.5 Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI) (Attachment F) and the ADHS/DBHS BQMO Specifications Manual, Complaint Reporting (Attachment K)

ADHS/DBHS defines a complaint as “*An expression of dissatisfaction with any aspect of care, other than the appeal of actions.*” Complaints may be filed directly with the Contractor and/or with ADHS/DBHS and may originate from behavioral health recipients, family members/guardians, providers, or other stakeholders, including Legislators, AHCCCS, the Governor’s Office and the Center for Disability Law. Complaints filed with ADHS/DBHS are directed back to the Contractor from which the involved behavioral health recipient receives services for action. The Contractors must inform ADHS/DBHS of the outcome of the complaint within timeframes specified by ADHS/DBHS Customer Service.

ADHS/DBHS delegates the tracking, resolution and reporting of complaint data for all TXIX/TXXI adults and children to its Contractors. The Contractors must include in these processes, at a minimum, the investigation and resolution of the complaint, any interventions implemented from the complaint data, and closure of the complaint. Any complaint may be elevated to the Contractor appeal and/or QOC processes as warranted by the complaint investigation findings.

ADHS/DBHS monitors this process through two Contractor reports submitted monthly to ADHS/DBHS OPI. First, complaint logs are submitted indicating the number of persons filing complaints each month, along with summarized information about the complaints. Additionally, Contractors report information about complaints resolved during the month in a separate monthly report in a template based on the AHCCCS Grievance System Reporting Guide. Both reports are described in the ADHS/DBHS BQMO Specifications Manual (Attachment K).

ADHS/DBHS defines an appeal as “*A request for review of an action.*” An “Action” is defined as:

- The denial or limited authorization of a requested service, including type and level of service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or part, of payment for a service
- The failure to provide a service in a timely manner
- The failure of a Contractor to act within the time frames for service as indicated contractually
- For an enrollee residing in a rural area with only one Contractor, the denial of an enrollee’s request to exercise the right to obtain services outside the Contractor’s network

ADHS/DBHS requires timely and complete Notices of Action (NOA) are provided to members or their legal representatives, consistent with AHCCCS requirements, when an action is taken in response to a request for service. The ADHS/DBHS Office of Grievance and Appeals (OGA), in conjunction with AHCCCS monitoring activities, conducts Notice of Action (NOA) audits of all ADHS/DBHS Contractors to measure compliance with AHCCCS and ADHS/DBHS NOA requirements. In addition to monitoring the procedural requirements and legal sufficiency of the NOAs, ADHS/DBHS reviews the NOAs for compliance with clinical decision-making expectations of AHCCCS and ADHS/DBHS, and provides follow-up to Contractors when clinical concerns are identified.

Appeals are initiated at the Contractor level, and if not resolved there, may be further appealed to ADHS/DBHS or AHCCCS, depending upon the appeal process used by the member (Title XIX/XXI Appeal Process or SMI Appeal Process).

ADHS/DBHS defines a grievance as: “*A complaint that is filed by a person with a Serious Mental Illness (SMI) or other concerned person regarding a violation of the person with SMI’s rights or a condition requiring an investigation.*” Like appeals, grievances are generally first filed with Contractors, and to the extent the client disagrees with the outcome, may be appealed further to ADHS/DBHS. ADHS/DBHS directly investigates the most serious grievances, client abuse and death cases.

ADHS/DBHS conducts quarterly audits of the Contractors to ensure adherence to procedural requirements, requiring corrections of any Contractor that is found non-compliant with the established standards. The quarterly review findings are used for scoring of the Contractors in the ADHS/DBHS Annual Administrative Review.

The ADHS/DBHS receives quarterly grievance system reports from Contractors. The reports summarize data and Contractor analysis, trending and follow-up action related to data on appeals, grievances, claims disputes and repetitive filings by individuals. The ADHS/DBHS Office of Grievance and Appeals reports pertinent findings in statewide grievance and appeals data to the ADHS/DBHS QM Committee quarterly. Complaint, grievance and appeals data are synthesized with data from other relevant data sources to

identify problematic system issues requiring corrective interventions. Corrective interventions can include CAPs, sanctions, and other contractual remedies.

ADHS/DBHS requires that Contractors ensure that all staff with direct contact with behavioral health members are trained to assist the member in the filing of all complaint, appeal, and grievance paperwork and the identification of means to resolve issues outside of the Contractor process, such as ADHS/DBHS Customer Service, ADHS/DBHS Office of Human Rights, local Human Rights Committees, and other available advocacy and support options.

Quality of Care (C-D-23, AMPM 910 C-5-e; 960 C, D)

ADHS/DBHS and its Contractors conduct QOC reviews of member care. The ADHS/DBHS Office of Performance Improvement (OPI) receives QOC issues from a variety of sources. If submissions contain immediate healthcare concerns, OPI contacts the DBHS Office of Customer Service. The general QOC process is as follows:

1. ADHS/DBHS Contractors and their providers are required to submit all Incident, Accident and Death (IAD) reports to ADHS/DBHS-BQMO/Office of Performance Improvement (OPI) for review and investigations.
2. QOCs are also submitted to BQMO/OPI from other internal and external agencies: Office of Behavioral Health Licensing (OBHL), Office of Consumer Rights, ADHS Director's Office, DES/DDD, Human Rights Agencies, Stakeholders and the Governor's Office. (C-D-23, AMPM 920 C-1-f, AMPM 960 C-1-c)
3. IADs and QOC concerns are entered by QOC Admin Support into a QOC database
4. IADs are reviewed by OPI-QOC staff in a weekly QOC Team meeting; Inter-Rater Reliability (IRR) checks are done on a weekly basis and potential QOC concerns are identified through consensus.
5. QOC staff initiate a QOC investigation process; reports of abuse, neglect and deaths are all considered potential QOC concerns and treated as such. If additional allegations are identified during the investigation process, they are added to the original QOC.
6. ADHS/DBHS assigns each QOC a level of severity and categorizes the QOC as per AHCCCS Contract, AMPM manual and ADHS/DBHS-BQMO Quality of Care Desktop Protocol (Attachment F).
7. A QOC opening letter is sent to respective Contractors for each potential QOC concern asking for investigation.
8. ADHS/DBHS notifies AHCCCS about the investigation's status through a weekly report, and closing timelines are identified for each potential QOC.
9. At the end of the process a closing letter is sent to AHCCCS.

Contractors must maintain a confidential file that documents their QOC review processes and make the data available to ADHS/DBHS OPI for review, as requested. The ADHS/DBHS QOC process operates under the protections provided by the A.R.S. and federal protections as follows:

[42 U.S.C. 1320c-9](#); [42 U.S.C. 11101 et seq.](#); [42 CFR 51.41 \(c\) \(4\)](#); [A.R.S §36-441-A.R.S. §36-445](#); [A.R.S. §36-2401](#); [A.R.S. §36-2402](#); [A.R.S. §36-2403](#); [A.R.S. §36-2404](#); [A.R.S. §36-2917](#); [A.R.S. § 36-3407](#); [A.R.S. §41-1092\(3\)](#); [A.R.S. §8-542 AHCCCS Medical Policy Manual \(AMPM\) 910\(A\) \(4\)](#); and [AHCCCS Medical Policy Manual, Chapter 900, Sections 910 & 960](#).

The ADHS/DBHS OPI is staffed with individuals who have the necessary clinical and administrative knowledge and skills to facilitate the investigation, evaluation, analysis, resolution, closure and trending of QOC issues (see BQMO Staff Job Descriptions section) (C-D-17, C-D-23-6, AMPM 960 C-1-a-b).

The ADHS/DBHS OPI is responsible for ensuring that each Contractor conducts a complete, timely and accurate resolution of the issues raised in the QOC. ADHS/DBHS reviews the Contractor's investigation, including whether the concern was substantiated, unsubstantiated or unable to be substantiated; and the severity of the QOC based on the substantiation. The ADHS/DBHS QOC process and Quality of Care Desktop Protocol are delineated in Attachment F.

Depending on the outcome of the investigation, ADHS/DBHS may refer QOC cases to the ADHS/DBHS Peer Review Committee as warranted by the QOC concern investigation (AMPM 960 C-6).

ADHS/DBHS requires and documents annual staff training on the QOC policy for all ADHS/DBHS employees having contact with members or providers (Attachment H), and the DBHS Workforce Development Unit includes Quality of Care training as part of the DBHS New Employee Orientation Training Requirements. The training assists staff in the identification and referral of potential quality of care concerns. FY 2011 QOC Training for all DBHS staff was completed on October 31st 2011 (Attachment G). In order to complete the training, staff was required to take a test with a passing score of seven (7) out of 10. A total of 56 staff participated and completed QOC training; participants were from-Customer Service, Grievance and Appeals, Cultural Competency, the Advocacy Group, CSOC, BQMO, Prevention, Grant Services and Compliance.

ADHS/DBHS oversees the QOC review process. First, it maintains Policy QM 2.7 Quality of Care Concerns (Attachment F) to guide ADHS/DBHS and Contractor QOC activities. Additionally ADHS/DBHS keeps a confidential member record that includes letters to Contractors, e-mails, findings, CAPs, research, documentation, and records reviewed by QOC designees from the ADHS/DBHS OPI.

ADHS/DBHS reports to AHCCCS weekly the number of QOCs identified for Title XIX and XXI members, and quarterly aggregates and reports the outcomes of these investigations (AMPM 920 – C-1-c and C-1-c-(1)-(6)). ADHS/DBHS also tracks, trends and aggregates QOC data on a Contractor level and presents the information to the ADHS/DBHS QM Committee quarterly (C-D-23-A-6-e, AMPM 920 C-2).

ADHS/DBHS monitors Contractor compliance with QOC requirements on a case-by-case basis as well as through the Annual Administrative Review. The Administrative Review tool specifically measures Contractors' compliance in developing CAPs to

reduce and/or eliminate the likelihood of the issue reoccurring, incorporation of successful interventions into the QM program based on the QOC review, assignment of new interventions as appropriate, and the maintenance of the process for resolving the concern from both a systems and a member perspective.

ADHS/DBHS Contractors are required to develop CAPs for problems identified through the QOC concern review process. The CAPs must promote quality and improved care for members receiving services in the behavioral health system. CAPs must address the following:

- Specified types of problems requiring corrective action
- Person or body responsible for making the final determination regarding quality issues
- Types of member/provider actions to be taken to include at a minimum:
 - Education/training/technical assistance
 - Follow up monitoring and evaluation of improvement
 - Changes in processes, structures, and forms
 - Informal counseling, termination of affiliation with provider, and/or appropriate referrals to regulatory agencies, including CPS, APS, and AHCCCS.
- Documentation of assessment of the effectiveness of actions taken
- Method for internal dissemination of findings and resulting work plans to appropriate staff and/or network providers
- Method for dissemination of pertinent information to AHCCCS and/or regulatory boards and agencies (Arizona Department of Health Services, Arizona Medical Board, Arizona State Board of Nursing, etc)

X. Performance Measures

(AMPM 970-B-1-b-(1)-(5)-(7), AMPM 970-B-1-(1)-(7), 7BBA 438.240 (a)(1), 438.240 (b)(1) and (d)(1), 438.240 (c)(I)(ii) and (2)); (C-D-23-A-9, C-D- B-I, AMPM 970 B-d-1, BBA 438.240 (e)(I)(i), BBA 438.240 (a) and (b), BBA 438.240 (c) (1, 2 and 3))

ADHS/DBHS follows the Plan, Do, Study, Act (PDSA) Quality Improvement cycle to evaluate data, assess performance, test interventions and refine activities as necessary. Through its contracts, ADHS/DBHS mandates the use of the PDSA model in every Contractor's QM activities. ADHS/DBHS and its Contractors participate in the continuous assessment and evaluation of system performance.

ADHS/DBHS has included AHCCCS-established minimum performance standard (MPS) and goals within its RBHA contracts and the ADHS/DBHS BQMO Specifications Manual (Attachment K). The current MPS and Goals are presented in the table on the following page.

ADHS/DBHS monitors each Contractor's performance on these measures quarterly. ADHS/DBHS and its Contractors incorporate monitoring of performance measures into provider monitoring processes and take actions, as necessary, to improve performance. The performance measures are reported separately for the TXIX/XXI Adult and Child populations.

Performance is also separately measured for members enrolled with the Arizona Department of Economic Security's Division of Developmental Disabilities (DES/DDD). Performance measure results are reviewed by the ADHS/DBHS QM Committee before submission to DES/DDD and AHCCCS. After approval, results are shared with the public and stakeholders through internal and external committees, such as the RBHA QM Coordinators Committee and DBHS Contractor Compliance Committees, and by publishing aggregate statewide performance measure reports on the ADHS/DBHS website and for analysis in the DBHS Outcomes Framework.

Performance Measure	Minimum Performance Standard	Goal
Access to Care	90%	95%
Behavioral Health Service Plan	85%	95%
Behavioral health Service Provision	85%	95%
Coordination of Care – Communication	85%	95%
Follow Up after Hospitalization for Mental Illness within 7 Days	70%	90%
Follow Up after Hospitalization for Mental Illness within 30 Days	80%	90%
Treatment of Depression	TBD	90%

ADHS/DBHS requires that each Contractor meets the established MPS for each measure per 42 CFR 438.240(b) (1), (2), and (d) (1). Additionally ADHS/DBHS requires continually improved performance measure outcomes from year to year as defined by the AHCCCS Medical Policy Manual (AMPM) Chapter 900. Statistically significant drops in statewide or an individual Contractor's performance level for any measure result in increased technical assistance, development of CAPs or sanction. ADHS/DBHS uses the following definitions for its performance measures:

1. *Access to Care:* The percent of AHCCCS members referred for or requesting behavioral health services for which the first service was provided within 23 days of the initial assessment.
2. *Behavioral Health Service Plan:* The percent of AHCCCS members with current service plans that incorporate the needs and service recommendations identified in their assessments.
3. *Behavioral Health Service Provision:* The percent of AHCCCS members who received the services that were recommended in their service plans.
4. *Coordination of Care (Communication):* The percent of AHCCCS members for whom behavioral health service providers communicate behavioral health clinical and contact information with the member's Primary Care Physician (PCP) and/or Health Plan (C-D-23, AMPM 910 A-1-p).

AHCCCS tracks the following measures:

5. *Follow up after Hospitalization for Mental Illness:* The percent of discharges for members age 6 years and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit or partial hospitalization

with a behavioral health practitioner, based on Healthcare Effectiveness Data and Information Set (HEDIS) criteria. Two rates will be reported: members who received follow up within 30 days of discharge and members who received follow up within 7 days of discharge.

6. *Treatment of Depression:* The percent of continuously enrolled AHCCCS members diagnosed with major depressive disorder of mild subtype who received an antidepressant medication or psychotherapy during the measurement period.

Performance Reporting for Special Populations

ADHS/DBHS identifies behavioral health recipients who are also enrolled in services with the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) as meeting the definition of special populations. The following ADHS/DBHS performance measures are monitored and reported for DES/DDD behavioral health recipients:

- Access to Care
- Coordination of Care – Communication
- Behavioral Health Service Plan
- Behavioral Health Service Provision

ADHS/DBHS reports performance for this special population separately in the FY11 Annual Performance Improvement Reports, in addition to sending quarterly reports on recipient utilization, Access to Care and Coordination of Care to DES/DDD.

XI. Performance Improvement Projects

(C-D-23-A-9, C-D-23-B-II, BBA 438.240(e)(1) and 438.240(d)(2) and AMPM 980-B-2)

ADHS/DBHS utilizes data derived from quality management activities in the development of PIPs per the AMPM Chapter 900 and the Provider Manual Section 8.4 Performance Improvement Projects (Attachment F). ADHS/DBHS may conduct PIPs for both clinical and non-clinical areas. The PIPs utilize structured methodologies as approved by AHCCCS for targeted improvement activities. Project topics are determined through data collection and analysis to identify a systemic improvement need.

Data reviewed includes, at a minimum, complaints, grievances, QOCs, performance measures and service utilization data. Projects are considered complete after improvement has been achieved and sustained for a year.

ADHS/DBHS utilizes PIP data in the creation and dissemination of practice protocols, policy development, and quality improvement activities. Contractors are required to participate in any and all activities, including interim monitoring, related to the completion of the following PIP:

Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services

The Coordination of Care PIP studies *whether improved coordination between AHCCCS Acute Care medical providers and behavioral health medical providers, including the targeted exchange of opiate and benzodiazepine prescribing data, reduce morbidity and/or mortality among AHCCCS members served through both systems.*

This PIP is co-owned by the ADHS/DBHS and AHCCCS, conceptualized by the ADHS/DBHS former Chief Medical Officer, Dr. Wilson, and implemented by AHCCCS with the help of its Health Plans.

The PIP was implemented in FY 2009 by AHCCCS; first re-measurement was scheduled for AHCCCS Contract Year 2010-2011. ADHS/DBHS-BQMO/OPI is committed to working with AHCCCS to assist with this PIP.

AHCCCS and ADHS/DBHS are co hosting meetings between AHCCCS Health Plans and ADHS/DBHS RBHAs for effective coordination and data sharing for improved performance.

As per the AHCCCS letter to ADHS/DBHS BQMO dated November 15, 2011, the ADHS/DBHS Self-Selected PIP requirement for CYE 2012 has been waived.

XII. Reporting Requirements

ADHS/DBHS reports all AHCCCS performance data per the AHCCCS/ADHS/DBHS contract deliverable schedule as defined by Contract#YH8-0002, Amendment 41 (July 1, 2011), “Attachment C: Periodic Reporting Requirements,” and “Summary of Due Dates.” ADHS/DBHS requires all Contractors to report performance measures and other QM data at least quarterly.

ADHS/DBHS QM Reporting

- Annual QM Plan, Work Plan and Evaluation
- Annual Consumer Survey
- Annual Performance Improvement Report (Child and Adult)
- Monthly Grievance System Report (Appeals and Claims Disputes)
- Performance Improvement Project Proposals and Interim Reports
- QM Quarterly Report (QOC Report)
- Weekly QOC Report to AHCCCS

ADHS/DBHS Contractor QM Reporting

- Annual Contractor QM Plan, Work Plan and Evaluation
- Quarterly Performance Improvement Report
 - Data included: Complaints, Performance Measures, CAPs, other proxy data such as QOCs
- Monthly Complaint Logs
- Monthly Complaint Resolution Summary (part of Monthly Enrollee Grievance Summary Report)
- Monthly QOC Reports
- Annual Consumer Survey Report

ADHS/DBHS QM also reviews data reports from other ADHS/DBHS functional areas in the ADHS/DBHS QM Committee. The following functional area reports are data feeds for ADHS/DBHS QM:

- Office of Grievance and Appeals Reports
- Adult and Child System of Care Reports
- ADHS/DBHS Quality Management Administrative Review CAP Status Reports
- Office of Individual and Family Affairs Reports
- Other data as identified

ADHS/DBHS ensures all deliverables are submitted to AHCCCS in a timely manner and are complete and error free. ADHS/DBHS Contractors must submit timely, logical and error free reports to ADHS/DBHS for the compilation of statewide reports to AHCCCS. ADHS/DBHS QM reports are reviewed by the ADHS/DBHS Leadership Team for approval prior to submission to AHCCCS.

XIII. List of Attachments

- A – FY2012 Quality Management Work Plan
- B – 2011 Quality Management Work Plan Evaluation
- C – 2011 Quality Management Program Evaluation Summary
- D – Peer Review Policy, Desktop Protocol, and Process Diagram
- E– Credentialing Tools
- F – QM Policies and Procedures
- G – ADHS/DBHS In-House QOC Training Materials
- H– 2012 Plan and Work Plan – QM Committee Approval by CMO
- I– 2012 Plan and Work Plan Approval – ADHS/DBHS Leadership Team
- J – 2012 QM Plan Checklist
- K – ADHS/DBHS 2012 BQMO Specifications Manual (Revised July, 2011 and submitted to AHCCCS 10/1/2011)
- L – Service Provision Tools



2012 Annual Quality Management Plan
(AHCCCS Contract Year October 1, 2011 – September 30, 2012)
(C-D-23, AMPM 910-A-1)

Kristy Benton, Office Chief
Office of Performance Improvement
Bureau of Quality Management Operations
Division of Behavioral Health Services

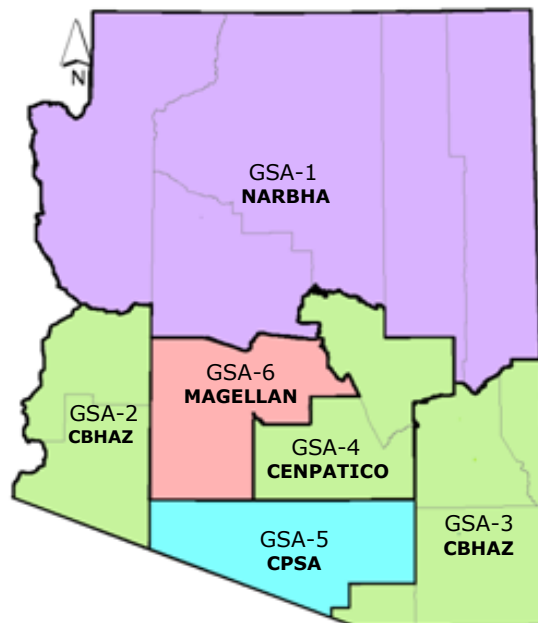
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I. Introduction

1. ADHS/DBHS System

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) serves as the single state authority that provides administration, regulation, and monitoring of all facets of the state publicly funded behavioral health system. ADHS/DBHS Contractors are community-based organizations known as Regional Behavioral Health Authorities (RBHAs) and Tribal Behavioral Health Authorities (TBHAs). ADHS/DBHS Contractors administer behavioral health services throughout the state and function in a fashion similar to health maintenance organizations. Contractors are responsible for the development of comprehensive service networks to provide a full continuum of behavioral health services for adults with substance abuse and general mental health disorders, adults with serious mental illness (SMI), and children.

The state is divided into six geographical service areas (GSAs) served by four Contractors:



- [Cenpatico Behavioral Health of Arizona](#) (CBHAZ) serves three GSAs (GSAs 2, 3 and 4) covering Pinal, Gila, Graham, Greenlee, Santa Cruz, Cochise, Yuma, and La Paz Counties.
- [Community Partnership of Southern Arizona](#) (CPSA) serves one GSA (GSA 5) covering Pima County.
- [Northern Arizona Behavioral Health Authority](#) (NARBHA) serves one GSA (GSA 1) covering Mohave, Coconino, Apache, Navajo, and Yavapai Counties.
- [Magellan of Arizona](#) (Magellan) of Arizona serves one GSA (GSA 6) covering Maricopa County.

In addition to these geographic service areas, ADHS/DBHS has Intergovernmental Agreements (IGAs) with three of Arizona's American Indian Tribes to deliver behavioral health services to persons living on the following reservations:

- [Gila River Indian Community](#)
- [Pascua Yaqui Tribe](#)
- [White Mountain Apache Tribe of Arizona](#)

2. Program Vision, Mission and Goals

ADHS/DBHS' vision for the delivery of quality behavioral health services provides the foundation for all Quality Management activities. The ADHS/DBHS vision states:

All Arizona residents touched by the public behavioral health system are easily able to access high quality prevention, support, rehabilitation and treatment services that have resiliency and recovery principles at their core, which assist them in achieving their unique goals for a desired quality of life in their homes and communities.

To support the ADHS/DBHS vision, the mission of the ADHS/DBHS BQMO is:

- Improve the quality of care provided to all behavioral health recipients;
- Improve behavioral health recipient satisfaction with services received; and
- Improve outcomes for all behavioral health recipients.

The 2012 ADHS/DBHS QM Plan is designed to achieve the goal of improved quality of care for behavioral health recipients utilizing evidenced-based practices, to meet or exceed AHCCCS requirements. Activities defined to support QM processes and program goals are delineated in the ADHS/DBHS QM Work Plan (Attachment A). These activities serve to direct and focus the ADHS/DBHS QM program and include clearly defined goals, measurable objectives, data feeds, responsible parties, frequencies of activities and target dates for activities completion

II. Scope of the QM Program

The ADHS/DBHS QM Plan includes all quality improvement activities conducted and managed by the Office of Performance Improvement (OPI) in BQMO, including the monitoring and oversight of Contractors' QM activities. ADHS/DBHS uses analysis of the behavioral health system's performance, feedback from behavioral health recipients and stakeholders, and evidence based practices to drive the performance improvement activities and new initiatives included in this Plan.

The ADHS/DBHS QM Plan includes monitoring reports and quality improvement activities pertaining to the following service categories and treatment settings:

Service Categories:

- Treatment Services
- Rehabilitation Services

- Medical Services
- Support Services
- Crisis Intervention Services
- Inpatient Services
- Residential Services
- Behavioral Health Day Programs

Treatment Settings:

- Level I Hospital
- Level I Psychiatric Hospital
- Level I Residential Treatment Center
- Level I Sub-acute Facility
- Level II Behavioral Health Residential
- Behavioral Health Outpatient Clinic
- Level III Behavioral Health Residential (non-IMD)
- Community Service Agency
- Behavioral Health Therapeutic Home
- Rural Substance Abuse Transitional Center
- Crisis Services Provider

Specific information regarding covered services and treatment settings can be found in the [ADHS/DBHS Covered Behavioral Health Services Guide](#).

Quarterly and Annual Evaluations

ADHS/DBHS conducts quarterly and annual evaluations of the Annual QM Work Plan (Attachments B and C) and reports the results to the QM Committee. Evaluation of progress toward meeting the QM Program goals is used to determine the scope of the coming year's activities and in the development of QM processes and performance improvement activities.

III. Quality Management Administrative Oversight

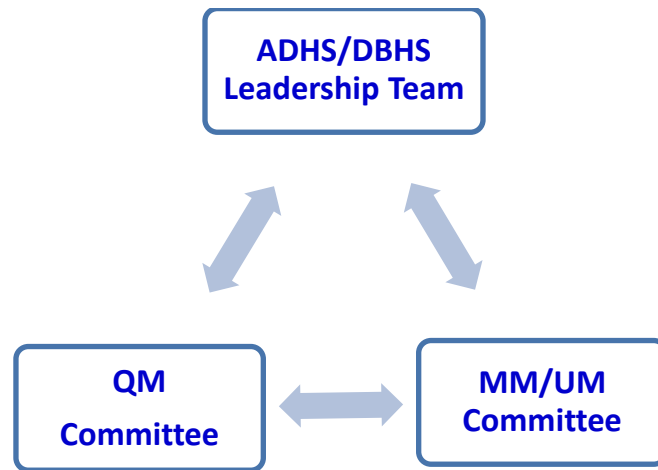
Structural Framework and Communication (C-D-23, AMPM 910-A-1-b)

The ADHS/DBHS Bureau of Quality Management Operations (BQMO) works collaboratively with all functional areas of ADHS/DBHS in the ongoing assessment and evaluation of the quality of services provided to behavioral health recipients. The ADHS/DBHS committees are utilized for decision making, performance monitoring, development of performance improvement activities, and as a means for incorporating stakeholder and member feedback into QM activities.

ADHS/DBHS Leadership Team

The ADHS/DBHS Leadership Team acts as the governing and policy making body for ADHS/DBHS. As seen in the diagram, the Leadership Team oversees the ADHS/DBHS QM program, providing strategic direction and ultimate authority for the scope of QM activities. The Leadership Team ensures ongoing communication between ADHS/DBHS QM and other ADHS/DBHS functional areas so that improvement activities are ongoing

and effective. As the diagram indicates, the Leadership Team is the final approval authority for all activities related to the ADHS/DBHS system of care.



Membership: Laura Nelson, M.D., Deputy Director, (**Chair**)
Robert Sorce, Assistant Director
Ann Froio, Assistant Director
Steven Dingle, M.D., Chief Medical Officer
Sara Salek, M.D., Deputy Chief Medical Officer
Cynthia Layne, Chief Financial Officer
Margery Ault, Branch Chief, Consumer Rights
Claudia Sloan MBA, Special Projects Administrator,

Meeting Frequency: Weekly

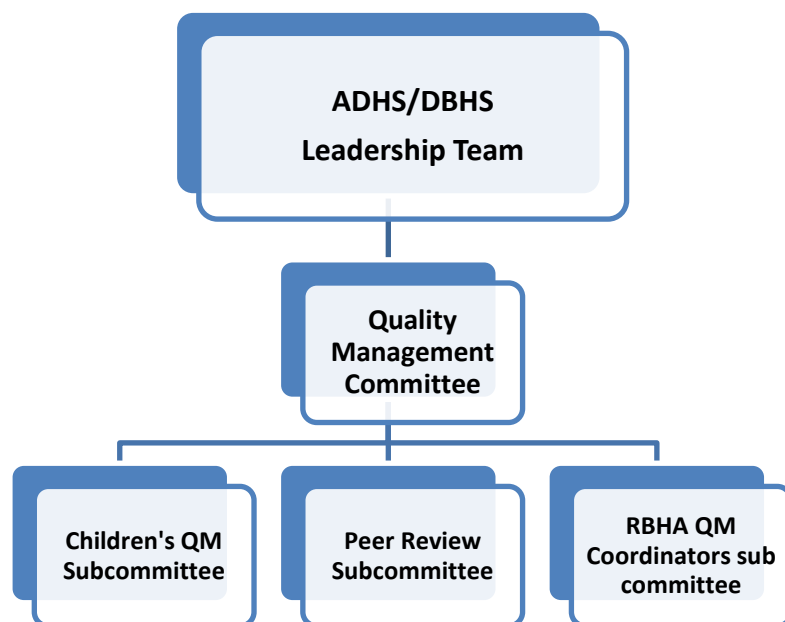
Quality Management Committee (ADHS/DBHS QM Committee)

(C-D-23, AMPM 910-C-1-a, AMPM 910-C-3-a-1-2-3-5, AMPM 920-C-1-b)

The QM Committee is chaired by the Chief Medical Officer (CMO) and co-chaired by the Manager of the Office of Performance Improvement (OPI) in the Bureau of Quality Management Operations (BQMO).

The ADHS/DBHS QM Committee ensures ongoing communication and collaboration between executive leadership and other functional areas of the Division and agency. Each ADHS/DBHS functional area is represented in the ADHS/DBHS QM Committee.

Committee members are informed of confidentiality and conflict of interest requirements related to serving on the committee. Sign-in sheets with confidentiality and conflict of interest language are completed at all meetings. The committee reviews, modifies, and updates QM program objectives, policies and procedures at least annually and completes quarterly status reviews of the QM Work Plan (C-D-17, C-D-23-A-1, C-D-23 6, 6-F, AMPM 910-C-3-b and e, AMPM 960-D-1-a).



Membership:

Voting Members

Steven Dingle, M.D., Chief Medical Officer (**Chair**)
 Kristy Benton, Office Chief, OPI (**Co-Chair**)
 Ashraf Lasee, Branch Chief, BQMO
 Margery Ault, Branch Chief, Consumer Rights
 Laura Nelson, M.D., Deputy Director
 Sara Salek, M.D., Deputy Chief Medical Officer
 Ann Froio, Assistant Director
 Cynthia Layne, Chief Financial Officer
 Margaret McLaughlin, Acting Branch Chief, Compliance
 Melissa Thomas, Acting Branch Chief, Program Operations
 Kathy Bashor, Office Chief, Office of Individual and Family Affairs

Non-Voting Members

Alexandra O'Hannon, Office Chief, Medical Management
 Office Chief, BQMO Information Management
 QM Staff: QOC RNs, Performance Measure RN/Specialist and PIP Coordinator

Meeting Frequency: Monthly

The ADHS/DBHS QM Committee receives feedback and recommendations for performance improvement activities from various subcommittees, work groups and other ADHS/DBHS functional areas. There are three subcommittees under the QM Committee:

1. The Children's QM Subcommittee
2. Peer Review Subcommittee
3. The QM T/RBHA Coordinators Subcommittee

The BQMO Medical Management/Utilization Management (MM/UM) Committee also provides semi-annual updates to the ADHS/DBHS QM Committee on MM/UM activities and makes recommendations to facilitate communication and coordination of improvement activities between QM and MM/UM programs.

Children's QM Subcommittee

The purpose of this subcommittee is to monitor quality management and improvement activities specific to children's services and improve practice according to the Arizona 12 Principles. This subcommittee reviews data that includes performance measures, member and family feedback, and outcome measures.

The Children's QM Subcommittee is chaired by the Deputy Chief Medical Officer and co-chaired by the Office Chief of the Office of Performance Improvement in the Bureau of Quality Management Operations (BQMO).

Subcommittee reports are presented quarterly to the ADHS/DBHS QM Committee to provide recommendations and clinical expertise into the development of specific measures for children.

Committee members are informed of confidentiality and conflict of interest requirements related to serving on the committee. Sign-in sheets with confidentiality and conflict of interest language are completed at all meetings.

Membership:

Sara Salek, M.D., Deputy Chief Medical Officer, **(Chair)**
Kristy Benton, Office Chief, OPI **(Co-Chair)**
Steven Dingle, M.D., Chief Medical Officer
Ashraf Lasee, Branch Chief, BQMO
Ann Froio, Assistant Director
Melissa Thomas, Acting Branch Chief, Program Operations
Kathy Bashor, Office Chief, Office of Individual and Family Affairs
Lou Ann Allard, Office Chief, Customer Service
Kimberly Engle, Office Chief, Children's System of Care
Kim Skrentny, Children's Clinical Advisor
Ronald Copeland, Implementation Manager, Children's System of Care
Steve Lazere, Implementation Manager, Children's System of Care
Kevin Flynn, Implementation Manager, Children's System of Care
Katie Jebraail, Implementation Manager, Children's System of Care
Robert Crouse, Implementation Manager, Children's System of Care

Meeting Frequency: Quarterly

Peer Review Committee

(C-D-23-6-e and AMPM 960-C-6, AMPM 910-C-4-(a-m))

The purpose of the ADHS/DBHS Peer Review Committee is to improve the quality of medical care provided to ADHS/DBHS behavioral health recipients and provide oversight and direction to the ADHS/DBHS Contractors in their peer review process.

Peer Review Committee activities include a review of cases where there is evidence of a quality deficiency in the care or service provided, or the omission of care or a service, by a person or entity that subcontracts with an ADHS/DBHS Contractor or Contractor's subcontractor to provide covered services directly to behavioral health recipients.

The ADHS/DBHS Peer Review Committee will examine selected RBHA peer review outcomes and information to monitor the RBHA peer review process. As the result of the review, the ADHS/DBHS Peer Review Committee will make recommendations to the RBHA Chief Medical Officer for further action, when indicated.

Cases for peer review are also identified through various ADHS/DBHS monitoring processes, including Quality of Care (QOC) concern reviews and incident, accident and death reviews. To guide these activities, ADHS/DBHS follows the Policy QM 2.6 Peer Review, Peer Review Desktop Protocol, and Peer Review Process (Attachment D).

The Peer Review Committee operates under the confidentiality protections afforded by state and federal law as follows:

[42 U.S.C. 1320c-9](#); [42 U.S.C. 11101 et seq.](#); [42 CFR 51.41 \(c\) \(4\)](#); [A.R.S §36-441](#); [A.R.S. §36-445](#); [A.R.S. §36-2401](#); [A.R.S. §36-2402](#); [A.R.S. §36-2403](#); [A.R.S. §36-2404](#); [A.R.S. §36-2917](#); [A.R.S. § 36-3407](#); [A.R.S. §41-1092\(3\)](#); [A.R.S. §8-542](#); [AHCCCS Medical Policy Manual \(AMPM\) 910\(A\) \(4\)](#); and [AHCCCS Medical Policy Manual, Chapter 900, Sections 910 & 960](#).

Membership¹:

Voting Members:

Steven Dingle, M.D., Chief Medical Officer, (**Chair**)
Kristy Benton, R.N., Office Chief, OPI (**Co-Chair**)
Sara Salek, M.D., Deputy Chief Medical Officer
Peer Review Coordinator, QOC RN, OPI
Internal and External Licensed Medical and/or Clinical Professionals

Non-voting members:

Laura Nelson, M.D., Deputy Director
Ashraf Lasee, Branch Chief, BQMO
Subject Matter Experts by Invitation Only

Meeting Frequency: Quarterly and *ad hoc* as needed.

¹ ADHS/DBHS uses external consultants when necessary specialty expertise is not available internally.

The T/RBHAs QM Coordinators Subcommittee Meeting

This subcommittee is chaired by the Office Chief of the Office of Performance Improvement and serves as the primary planning, policy and problem-solving communication channel between ADHS/DBHS Quality Management (QM) program and its Contractors. The main objective of the T/RBHAs QM Coordinators subcommittee is to disseminate ADHS/DBHS information, provide technical assistance, and receive feedback from the Contractors. The goal is to enhance ADHS/DBHS oversight of the Contractors' QM processes and activities, share QM data, incorporate ADHS/DBHS Contractors and their providers' input into the ADHS/DBHS QM system and improve Contractor compliance with QM contractual requirements.

Statewide quality management initiatives are discussed and technical assistance is provided by ADHS/DBHS. The meetings incorporate a roundtable discussion in which the Contractors can provide feedback to ADHS/DBHS QM and brainstorm best practices for incorporation into QM activities. In addition to quarterly meetings, ADHS/DBHS may call *ad hoc* meetings with Contractors to review new or revised QM requirements, report performance measures specifications, discuss the QM Plan and Work Plan, etc.

Membership:

Kristy Benton, R.N., Office Chief, OPI, (**Chair**)
Ashraf Lasee, Branch Chief, BQMO
BQMO Performance Improvement Specialists
Alexandra O'Hannon, Office Chief, Office of Medical Management
Office Chief (vacant) Office of Information Management
RBHAs Quality Management (QM) Coordinators/Directors

Meeting Frequency: Quarterly

ADHS/DBHS QM Staffing Description

The ADHS/DBHS BQMO's Office of Performance Improvement (OPI) has general responsibility for the ADHS/DBHS Quality Management functions. ADHS/DBHS OPI is staffed with individuals who have the knowledge and experience to perform QM activities within each function/performance area: Quality of Care (QOC) Concerns, Performance Measure tracking, monitoring and oversight, Performance Improvement Project (PIP), ADHS/DBHS Annual Consumer Survey, and other programmatic and administrative activities.

BQMO/OPI Staff Job Descriptions

Chief Medical Officer - Steven Dingle, M.D.: is the ADHS/DBHS Chief Medical Officer (CMO); who is an Arizona-licensed physician (Psychiatrist). The CMO is responsible for:

- Chairing the ADHS/DBHS Quality Management Committee and the Peer Review Subcommittee
- Providing clinical oversight of the Quality of Care (QOC) process

- Working with RBHA Chief Medical Officers on issues related to QOC and Peer Review
- Providing direction and input into ADHS/DBHS Performance Improvement Projects

Branch Chief, Bureau of Consumer Rights - Margery Ault, J.D.: The ADHS/DBHS Branch Chief for the Bureau of Consumer Rights reports to the ADHS/DBHS Deputy Director. The Branch Chief (Consumer Rights):

- Provides administrative, executive-level leadership, guidance and support for BQMO as well as the Offices of Human Rights, Grievance and Appeals and Customer Service.
- Serves as a member of ADHS/DBHS' Leadership Team

Branch Chief, BQMO - Ashraf Lasee, M.B.B.S, M.P.H., Dr. P.H.: The Branch Chief for the Bureau of Quality Management Operation is responsible to ensure ongoing communication and collaboration between executive leadership, BQMO, and other functional areas of the Division of Behavioral Health Services; provides administrative support and technical assistance to three Offices in the Bureau: Office of Performance Improvement (OPI), Office of Medical and Utilization Management (MM/UM), and the Office of Information Management; and provides leadership to communicate program related issues and needs with AHCCCS. On a daily basis, the Branch Chief is responsible for:

- Focusing organizational efforts on improving clinical quality performance measures
- Developing and implementing performance improvement projects
- Utilizing data to develop intervention strategies to improve outcomes
- Reporting quality improvement and performance outcomes
- Managing the BQMO which includes the Offices of Performance Improvement and Medical Management/Utilization Management
- Ensuring compliance with the Arizona Health Care Cost Containment System; (AHCCCS) Medical Provider Manual (AMPM) Chapter 900 (Quality Management) and Chapter 1000 (Utilization Management)
- Monitoring AHCCCS Performance Measures, including: access to care, coordination of care, behavioral health service plan and behavioral health service provision; consumer satisfaction; and others by all contractors and tribal partners to improve performance

Office Chief, Office of Performance Improvement (OPI) - Kristy Benton, R.N., B.S.N., M.P.H.: The Office Chief for the Office of Performance Improvement reports to the Branch Chief for the BQMO. The Office Chief is responsible for:

- Managing a team of eight OPI staff
- Overseeing the day-to-day operations of the OPI
- Ensuring OPI's and its Contractors' compliance with AMPM 900
- Providing direct supervision to the Quality of Care Process and related issues
- Co-Chairing QM Committee with ADHS/DBHS Chief Medical Officer

- Coordinating performance improvement activities with AHCCCS, ADHS/DBHS contractors, tribal partners, consumers and family members, and other stakeholders and workgroups
- Providing technical assistance regarding ADHS/DBHS requirements, processes and operational matters to ADHS/DBHS contractors and tribal partners
- Overseeing and facilitating the Administrative Review Process of T/RBHAs in the quality management area
- Coordinating the QM components of AHCCCS' Operational and Financial Review process for ADHS/DBHS
- Overseeing and facilitating the bi-annual data validation activities
- Writing, revising and updating QM area policies and procedures for both internal and external use

QOC Program Lead - Linda Ellen Holmes M.B.A, ADN: The QOC Lead is responsible for:

- Coordinating the procedural and substantive QOC activities of all staff conducting QOC reviews
- Reviewing all Incident, Accident, and Death (IAD) reports submitted by RBHAs and other sources on a regular basis; conducting and monitoring inter rater reliability checks among reviewers on a weekly basis
- Tracking and trending QOCs; developing weekly and quarterly QOC tracking reports
- Monitoring and evaluating quality of care data to determine any trends related to quality of care in ADHS/DBHS' systems of care
- Coordinating the Peer Review subcommittee with DBHS Chief Medical Officer
- Coordinating Peer Review related activities with Contractors' CMOs
- Ensuring compliance with federal, state, and contractual requirements

QOC Program Staff - Earlene Allen, R.N., M.C. (Masters in Counseling), Michele Reese, R.N. (starts 12/26/2011) and a QOC Analyst: The QOC Program staff job responsibilities include, but are not limited to:

- Reviewing Incident, Accident and Death (IAD) reports and identifying potential QOC concerns
- Receiving and reviewing potential QOC concerns from ADHS/DBHS staff and outside agencies
- Communicating these potential concerns with Contractor QOC personnel
- Assessing and evaluating the care provided to individuals receiving services based on the results of QOC investigations
- Monitoring and evaluating level and quality of care to improve services, and
- Appraising and assessing whether existing services are meeting the needs of individuals receiving services in the community

Performance Improvement Project (PIP) Coordinator - Jennifer Tonges, B.A. Psychology: PIP coordinator's responsibilities include, but are not limited to:

- Coordinating the development, design and implementation of PIP projects
- Developing PIP project proposals and updates to current PIPs
- Assisting other OPI staff as needed

Performance Measure Program Lead - (Grade 22 RN position-Interviews in process): The Performance Program Lead will report to the Office Chief, OPI. The responsibilities include, but are not limited to:

- Coordinating the work of two performance improvement staff
- Organizing and directing Annual Administrative Reviews and ongoing data validation activities in the area of performance measures, credentialing and the Medical Record Review
- Developing annual performance improvement reports and correspondence
- Providing feedback and technical assistance as necessary to ADHS/DBHS Contractors and tribal partners on performance measures, reports, and OPI policies and procedures
- Addressing the core business functions of OPI as described in the annual QM Plan
- Attending meetings internally and externally on quality improvement and OPI administration topics

Performance Measure Program Staff - (Patricia Valez and two vacant positions which are in the hiring process): The Performance Measure Staff responsibilities include, but are not limited to:

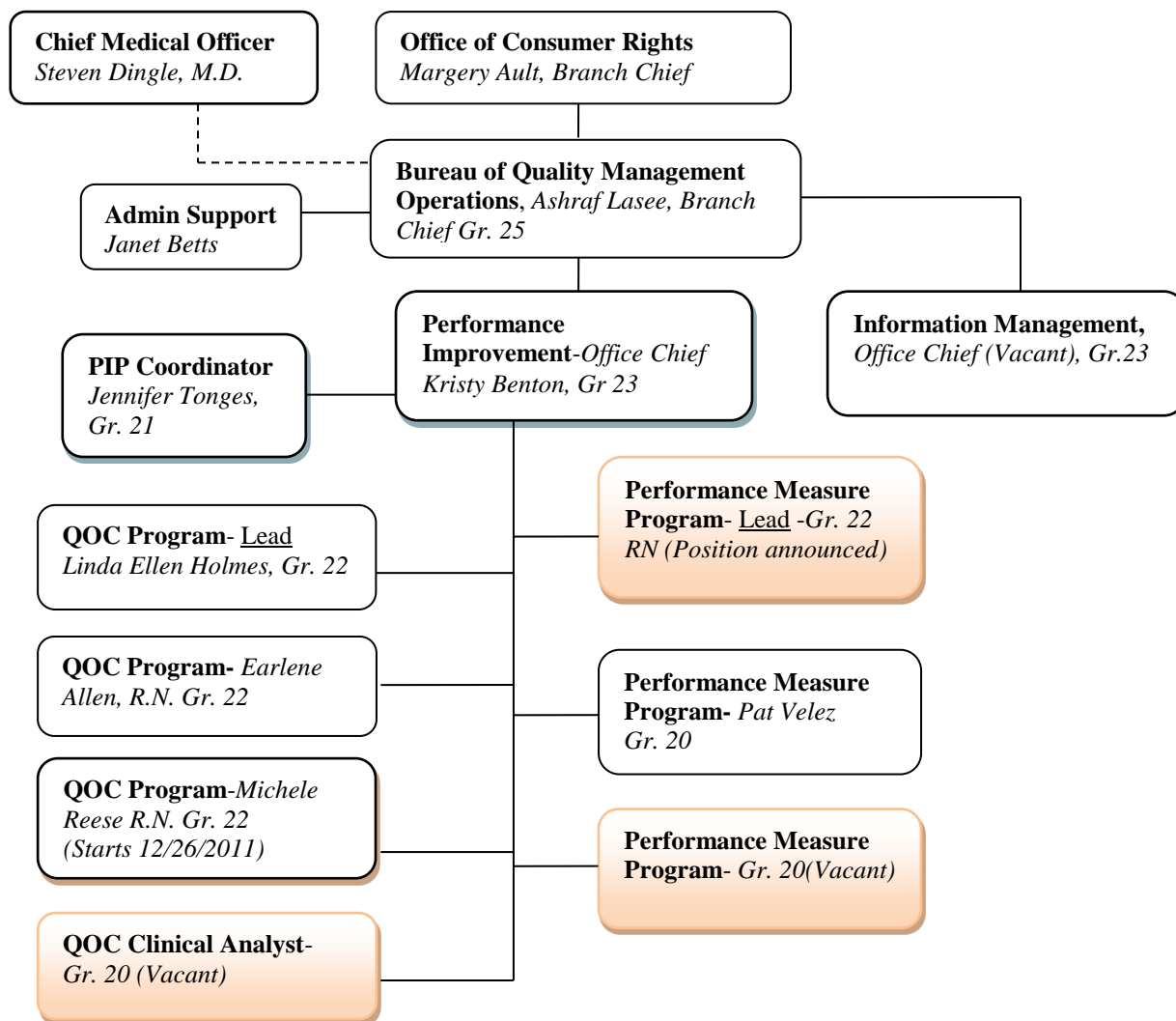
- Participating in the development and execution of performance improvement activities based on data analysis and AHCCCS requirements
- Completing quarterly reviews and analyzing contractors' performance related to specific performance measures
- Conducting semi-annual data validation activities and monitoring of corrective action plan(s) submitted by the ADHS/DBHS Contractors
- Completing *ad hoc* and focused reviews, as required by the Chief of the Office of Performance Improvement
- Providing technical assistance to Contractors regarding performance improvement activities
- Addressing core business functions of OPI as described in the annual QM Plan

Office of Information Management: The Information Management (IM) Office Chief works with a team of three full time staff (Carolyn Dempsey, Vanessa Cardenas and Rahnuma Khandaker) and a part time consultant (Julie Karcis, NP, M.P.H). The OIM staff assist with quality and utilization management data needs in the BQMO as follows:

- Tracking incoming and outgoing QM and MM/UM Deliverables
- Assisting OPI in data analysis for the ADHS/DBHS Annual Consumer survey, AHCCCS Enrollee Grievance Report (Complaint Resolution Summary), Performance Measure evaluation and improvement activities, developing visual presentations for the QM Committee meetings
- Developing utilization reports on SMI eligibility determinations, length of stay (LOS), re-admission rates, RBHA prior authorizations, and pharmacy utilization for provider monitoring and oversight, and evaluating Contractors' compliance

- Developing At-a-Glance Charts and Graphs for Performance Measures, Complaints, Quality of Care trending and Utilization Management measures
- Monitoring and updating the ADHS/DBHS Outcomes Dashboard
- Developing ADHS/DBHS-BQMO Specification manual – a manual for ADHS/DBHS and T/RBHA staff describing how to generate QM and MM/UM area data and reports per AHCCCS Requirements (Attachment K)
- Assisting ADHS/DBHS Finance and Contract Compliance Bureaus for Annual Performance Incentives calculation and evaluation

Office of Performance Improvement - Org Chart



Collaboration with other ADHS/DBHS Functional Areas:

In addition to the functional areas within the BQMO, another ADHS/DBHS organizational area plays a significant role in supporting BQMO operations. The Bureau of Business Information within ADHS/DBHS supports the integrity of Client Information System through publications such as the Demographics Users Guide (DUG) and the Operations and Procedures Manual, which provide guidelines to data reporting structures for claims and demographic data. Both Offices also implement data integrity processes such as audits and data checks on contractor-submitted data.

IV. Quality Management Plan Activities

(C-D-17, C-D-23-A-1, AMPM 910-C-3-e, AMPM 920-B-2)

This section describes all ADHS/DBHS (internal) and Contractor (external) quality improvement activities and processes. ADHS/DBHS mandates that all Contractors incorporate ADHS/DBHS' quality improvement activities into their QM Plans.

Monitoring and Evaluation Activities (C-D-23-B-II, AMPM 920-B-3, AMPM 940-2-b-c)

ADHS/DBHS QM conducts monitoring and evaluation of QM activities through monthly and quarterly direct data reports from its Contractors, focused *ad hoc* reviews and annual administrative reviews. The following are descriptions of all ADHS/DBHS QM activities.

Data Integrity Activities (C-D-38, AMPM 910-A-1-q, BBA-488.242(b)(3))

Accurate and reliable data is imperative for the success of the ADHS/DBHS QM program. Per Provider Manual Section 7.5, Enrollment, Disenrollment and Other Data Submissions (Attachment F), Contractors are required to maintain a health information system which includes data elements such as member demographics, service utilization, provider characteristics, episode of care status, outcomes measures and diagnoses for use in ADHS/DBHS and Contractor QM activities.

Data submitted to the ADHS/DBHS Client Information System (CIS) must pass a series of validation measures and logic safeguards prior to acceptance. Each validation measure or edit is designed to operate in a specific manner to ensure accuracy, completeness and logic. ADHS/DBHS provides direction related to systems edits and business rules to its Contractors through the [Demographic and Outcome Data Set Users Guide \(DUG\)](#).

To improve the quality of data submitted directly to ADHS/DBHS QM for performance monitoring and evaluation, ADHS/DBHS developed the BQMO Specifications Manual (Attachment K) which includes details on the ADHS/DBHS methodologies for calculating and reporting all performance indicators. ADHS/DBHS mandates that Contractors use standardized report templates and methodologies as outlined in the BQMO Specifications Manual in their QM reporting. The standardization of reporting ensures consistency in collection and reporting of critical data elements across Contractors for improved analysis on a statewide level.

ADHS/DBHS quality of care (QOC) and performance measure staff participate in inter-rater reliability (IRR) exercises regularly to ensure consistency in staff interpretation of review questions and documentation ratings, thereby increasing the reliability of the review process. ADHS/DBHS BQMO conducts data validation activities twice a year to support the integrity of data reported by its Contractors. Contractors failing to meet the minimum performance standards are required to submit corrective action plans.

ADHS/DBHS-BQMO Review Activities

Annual Administrative Review

The Bureau of Quality Management Operation staff conducts annual comprehensive operational and financial reviews of each Contractor to assess compliance with contractual requirements and quality management standards and perform data validation activities. ADHS/DBHS establishes scoring criteria for each indicator reviewed. Contractors falling below performance expectations are required to develop corrective action plans (CAP) that reflect interventions to improve future performance. Contractor CAPs are monitored and tracked by the ADHS/DBHS Bureaus of Quality Management and Compliance, and the status of each CAP is reported quarterly to the ADHS/DBHS QM Committee.

ADHS/DBHS conducted its 2011 Annual Administrative Review during October and November of 2011 according to the following schedule:

- Magellan 10/11/2011 - 10/13/2011
- CPSA 10/18/2011 - 10/20/2011
- NARBHA 10/25/2011 - 10/27/2011
- Cenpatico 11/02/2011 - 11/04/2011
- Gila River, Pascua Yaqui and White Mountain desk review – Nov-Dec, 2011

The Administrative Review *Schedule* and the *Tool* were developed and shared with AHCCCS for feedback and Comments.

At the end of each RBHA Administrative Review, an Exit Interview was conducted with RBHA staff for preliminary feedback and a performance update; and also to provide them an opportunity to submit additional documentation to demonstrate their performance.

Administrative Review scores for each standard are in the process of being finalized; final reports will be shared with RBHAs to assist them in developing corrective action plans.

Data Validation Reviews

ADHS/DBHS OPI conducts biannual on site data validation activities to ensure the accuracy of data used to evaluate Contractor performance in QM area. Data validation findings are reported to the ADHS/DBHS QM Committee. Discrepancies in Contractor reported data and the data validation review findings are addressed through targeted

technical assistance, performance improvement plans and further corrective actions as needed.

Incident/Accident and Death (IAD) Report Reviews

ADHS/DBHS requires its Contractors to report incidents, accidents and deaths per Policy QM 2.5 (Reports of Incident, Accident, and Death), and Provider Manual Section 7.4 (Reporting of Incident, Accident and Death), and as outlined in ADHS/DBHS BQMO Specifications Manual. Contractors are required to report significant and/or adverse incidents for all enrolled behavioral health recipients. These incidents are reported to ADHS/DBHS within one day of the notification to the Contractors.

The Contractors are required to electronically submit to the ADHS/DBHS all mortalities, incidents of sexual and physical abuse, morbidities that require medical intervention, incidents of absence without leave (AWOL) from Level I facilities, medication errors that result in adverse outcomes, and human rights related violations etc.

ADHS/DBHS QOC staff review Incident, Accident and Death (IAD) reports and identify potential QOC concerns. Inter Rater Reliability (IRR) checks are conducted on a weekly basis for a select sample of cases to ensure consistency in reviewers' findings. These potential QOC concerns are communicated with respective Contractor QOC personnel for investigation. Contractor data is aggregated on a statewide level and presented to the QM Committee.

QOC concerns can also be referred to ADHS/DBHS Peer Review subcommittee for further review and recommendation. QOC and Peer Review activities are protected under the following Arizona Revised Statute (A.R.S.) and federal protections:

[42 U.S.C. 1320c-9](#); [42 U.S.C. 11101 et seq.](#); [42 CFR 51.41 \(c\) \(4\)](#); [A.R.S §36-441-](#)
[A.R.S. §36-445](#); [A.R.S. §36-2401](#); [A.R.S. §36-2402](#); [A.R.S. §36-2403](#); [A.R.S. §36-2404](#);
[A.R.S. §36-2917](#); [A.R.S. § 36-3407](#); [A.R.S. §41-1092\(3\)](#); [A.R.S. §8-542 AHCCCS](#)
[Medical Policy Manual \(AMPM\) 910\(A\) \(4\)](#); and [AHCCCS Medical Policy Manual](#),
[Chapter 900, Sections 910 & 960](#).

Peer Review (C-D-23-6-e and AMPM 960-C-6)

ADHS/DBHS conducts peer reviews at least quarterly within the Peer Review Committee. The purpose is to improve the quality of care provided to behavioral health recipients. The Peer Review Committee selects and reviews cases where there is evidence of inadequate and/or substandard care; inappropriate utilization of services, which includes a quality deficiency or omission of a service; and adverse outcomes, including morbidities and mortalities. The Committee may also review Contractor's Quality of Care (QOC) and non-QOC complaints.

ADHS/DBHS requires all Contractors to conduct Peer Reviews in accordance with the AMPM Chapter 900, and ADHS/DBHS Policy QM 2.6 (Peer Review Policy) (included in Attachment D).

ADHS/DBHS monitors Contractor peer review activities biannually through the ADHS/DBHS data validation and Administrative Review; and quarterly within the Peer

Review Committee. The Peer Review Committee operates under A.R.S. and federal protections:

[42 U.S.C. 1320c-9](#); [42 U.S.C. 11101 et seq.](#); [42 CFR 51.41 \(c\) \(4\)](#); [A.R.S. §36-441-A.R.S. §36-445](#); [A.R.S. §36-2401](#); [A.R.S. §36-2402](#); [A.R.S. §36-2403](#); [A.R.S. §36-2404](#); [A.R.S. §36-2917](#); [A.R.S. § 36-3407](#); [A.R.S. §41-1092\(3\)](#); [A.R.S. §8-542 AHCCCS Medical Policy Manual \(AMPM\) 910\(A\) \(4\)](#); and [AHCCCS Medical Policy Manual, Chapter 900, Sections 910 & 960](#).

Provider Monitoring

ADHS/DBHS requires Contractors to conduct on-site provider monitoring for all subcontractors at least annually; more frequent provider monitoring may take place for subcontractors demonstrating performance below minimum standards and as data evaluation indicates. Contractors are required to develop a mechanism for a focused review of provider sites as identified through trended data. As part of their provider monitoring, Contractors are required to implement processes for verifying the accuracy and timeliness of reported data, inter-rater reliability exercises, and the standardized collection of service information. Contractors must utilize provider monitoring data to implement performance improvement activities that are data driven, outcomes focused and systemic in scope to improve the quality of services provided to their members. Contractors include detailed provider monitoring plans in their Annual QM Plans, including a schedule and frequency of provider monitoring activities and provider monitoring tools. ADHS/DBHS oversees Contractor provider reviewing and approval of its Contractors' processes for meeting these requirements during biannual site visits.

Provider Profiling

ADHS/DBHS requires its Contractors to complete Provider Profiling quarterly as part of the provider monitoring process. Minimum provider profiling data elements must include ADHS/DBHS performance measures, complaints, grievance and appeals data, and ADHS/DBHS MM/UM measures.

ADHS/DBHS Contractors are required to develop a Provider Profile for each subcontractor by provider and/or service site and take corrective action to address deficiencies identified through trended data. Profiling data is used to improve recipient outcomes, support quality practice, and in the development of performance improvement activities to affect positive change for the Contractor, its providers, the service site, and the members' quality of care.

ADHS/DBHS Contractor's Provider Profiles are available for review in Contractor Dash Board reports located on each Contractor website.

ADHS/DBHS conducts Contractor Profiling activities quarterly through the synthesis of Contractor performance, utilization, compliance and review data. ADHS/DBHS presents these data across Contractors in various ADHS/DBHS committees and in reports to AHCCCS that are available to stakeholders and members for review at the [ADHS/DBHS website](#). ADHS/DBHS also utilizes Contractor profiling data for focused reviews, in the

development of Performance Improvement Projects (PIPs) and in the Request for Proposal (RFP) process.

Consumer Surveys (C-D-23, AMPM 910-A-1-n, BBA 438.202 (b))

ADHS/DBHS Bureau of Quality Management Operations conducts two annual consumer surveys: (1) Adult Consumer Survey, and (2) Youth Survey, based on the Substance Abuse and Mental Health Administration (SAMHSA) Mental Health Statistics Improvement Program (MHSIP) surveys.

The surveys request independent feedback from Title XIX/XXI adults and families of youth receiving services through Arizona's publicly funded behavioral health system. The surveys measure consumers' perceptions of behavioral health services in relation to the following domains:

- General Satisfaction
- Access to Services
- Service Quality/Appropriateness
- Participation in Treatment Planning
- Outcomes
- Cultural Sensitivity
- Improved Functioning
- Social Connectedness

ADHS/DBHS BQMO presents Consumer Survey data in the ADHS/DBHS Quality Management (QM) Committee. Contractor performance on outcome domains is used to measure the RBHA's eligibility for a financial incentive. Additionally, member satisfaction with *Access to Service* and *Participating in Treatment Planning* are two main indicators in the ADHS/DBHS Outcomes Framework and Dashboard.

ADHS/DBHS compiles statewide survey data into an annual deliverable reported to AHCCCS, submits survey data to SAMHSA's MHSIP, and publishes it on the ADHS/DBHS website (FY2011 Consumer survey submitted to AHCCCS on 12/15/11).

Coordination of Care (COC) (C-D-12, AMPM 910-A-1-p)

ADHS/DBHS is committed to improving the coordination and communication of member care between the behavioral health system and members' AHCCCS Primary Care Physicians (PCPs) and/or their AHCCCS Health Plan Coordinators. At a minimum, 85 percent of member files reviewed must contain appropriate documentation of communication with the member's primary care physician. Any Contractor falling below the *minimum performance standard* (MPS) is subject to corrective action and must develop a corrective action plan identifying interventions to improve and sustain compliance.

The ADHS/DBHS definition of COC is included in QM Plan Section XI (*Performance Measures*); the methodology for calculating the COC performance measure is explained in the ADHS/DBHS BQMO Specifications Manual (Attachment K). Policies and provider manual sections that support the ADHS/DBHS COC performance measures

include ADHS/DBHS Provider Manual 3.3 (Referral and Intake Process) and Provider Manual Section 4.3-*Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers* (Attachment F).

Outcomes Dashboard

All ADHS/DBHS QM processes and activities are designed to foster positive clinical and social outcomes for behavioral health recipients. In FY 2011, ADHS/DBHS implemented an outcomes framework that assesses the impact of ADHS/DBHS programs and initiatives on behavioral health outcomes. Primary indicators are defined using Client Information System (National Outcome Measures [NOMS]), the ADHS/BHS Annual Consumer Survey, QM performance measures data, MM/UM data, and network analyses.

The framework organizes these priority indicators into the four following categories, which are reported in a series of scorecards that collectively form the Outcomes Dashboard:

1. Access;
2. Service Delivery;
3. Coordination/Collaboration; and
4. Outcomes.

Statewide	
Outcomes: Individuals . . .	Has quality of life improved for individuals served by the behavioral health system?
With a drug/alcohol use history are now abstaining	30.8%
Are not homeless	97.5%
Are employed	14.2%
Attend school	36.4%
Have no recent criminal justice system involvement	93.7%
Participate in self-help groups	Coming in 2012

The Dashboard is published on the ADHS/DBHS website for review by the public, contractors, providers and consumers: <http://www.azdhs.gov/bhs/dashboard/index.htm>

The Dashboard QM outcomes measures are developed by the BQMO Office of Information Management (OIM) and presented in the Quality Management Committee for review and approval. Outcomes Dashboard data are often discussed in the Leadership Team to assess the effectiveness of the System; develop strategic direction and recommendations, and to monitor Contractor progress on score cards.

Actions for Improvement (C-D-23-A-6-e, AMPM 920-C-1-a-b-c-6, AMPM 920-C-1-d)

ADHS/DBHS uses technical assistance and, where necessary, corrective action or other contractual remedies to correct the actions of Contractors exhibiting low performance on any of the AHCCCS or ADHS/DBHS performance indicators. ADHS/DBHS Contractors are required to incorporate the PDSA (Plan, Do, Study, Act) Model for continuous quality improvement in Corrective Action Plans (CAPs). CAPs must include: (1) measurable goals and objectives, (2) interventions, activities and tasks, (3) responsible parties, and (4) start and completion dates for each activity and task identified in the submitted CAP. The Contractors must include systemic interventions that include, but are

not limited to, training, policy review and revision, technical assistance and focused reviews. Contractor CAPs must utilize evidence-based practices in the reported interventions to meet and/or exceed performance expectations.

ADHS/DBHS BQMO approves and monitors all Contractor CAPs and mandates that Contractors report CAP performance quarterly. ADHS/DBHS BQMO reports the status of statewide QM CAPs to the QM Committee; the Contractor specific improvement plans are also presented within the ADHS/DBHS Compliance meetings. The ADHS/DBHS Leadership Team is the ultimate decision making body for approving CAP compliance and directing the levying of further corrective actions, including contractual remedies such as sanctions or notices to cure, as indicated. (C-D-23, AMPM 920-C-1-e)

QM Policy Development or Revision (C-D-17, AMPM 940-A-1-o)

The ADHS/DBHS Policy Committee has developed a schedule and protocol to monitor the revision of division-wide policies and procedures based on the AHCCCS-ADHS/DBHS Contract, and program requirements. Policies are revised at least annually or as necessary. All revised policies are presented in the QM Committee meeting for feedback and preliminary approval, and approved policies are then presented to ADHS/DBHS Policy Committee for justification of revisions. Policies are then sent out for Public Comments; after reviewing public comments, policies are revised if needed. Final policies are again presented to the QM Committee for final approval. Attachment F contains all QM policies.

V. Delegated Functions

(C-D-23, C-D-23-A-5, AMPM 910-A-1-h, AMPM 950-B-3)

ADHS/DBHS delegates the following QM functions to its Contractors as delineated in the ADHS/DBHS/RBHA contracts:

- A comprehensive QM program that includes all the required components within the ADHS/DBHS QM Plan, the AHCCCS AMPM Chapter 900, Policy 910 and the ADHS/DBHS/RBHA Contracts
- QI Committee
- Quality of Care concerns reporting and investigation
- Tracking and Trending of Member Complaints, Grievances, and Appeals
- Developing and Disseminating Member Handbooks
- Medical Record Maintenance
- Credentialing, Re-credentialing, Organizational credentialing and Provisional credentialing of all sub-contracted providers
- Provider Monitoring and Profiling

ADHS/DBHS provides oversight and retains ultimate accountability for all functions delegated to its Contractors (C-D-23, AMPM 910-C-6-e). Contractor quarterly and *ad hoc* reports, focused reviews, data validation site visits, and the Annual Administrative Review serve as the mechanisms by which ADHS/DBHS monitors delegated functions. Furthermore, the Contractors must do the following for activities they delegate to their providers:

- Execute a written agreement specifying the delegated activities and reporting responsibilities of the entity, including providing for revocation of the delegation or other remedies for inadequate performance

- Evaluate the entity's ability to perform the delegated activities prior to delegation
- Conduct ongoing monitoring of performance and the quality of services provided
- Annually review the delegated entity's performance
- Maintain, for ADHS/DBHS' review, evaluation reports and CAPs, as necessary, to ensure quality for all delegated activities

VI. Member Rights and Responsibilities

The ADHS/DBHS Contractor Member Handbooks are designed to provide behavioral health recipients and potential enrollees with information about services provided in the ADHS/DBHS system of care and information on member rights and responsibilities, including the complaint and grievance system requirements and the means to resolve issues outside of the Contractor's specific processes (such as ADHS/DBHS Customer Service).

Contractors must provide each member with a Handbook within 10 days of the member's first service. ADHS/DBHS utilizes the Administrative Review to monitor Contractor compliance with this policy and procedure. Handbooks must be easily accessible by all behavioral health recipients and potential enrollees. Members have the right to receive a Handbook at least annually.

The ADHS/DBHS Provider Manual Section 3.6 (Member Handbooks-Attachment F) delineates the mandatory components for each Contractor Member Handbook and is approved by AHCCCS before dissemination of these requirements to ADHS/DBHS Contractors. ADHS/DBHS provides the Contractors with the Handbook template and no revisions to the Handbooks may be made without prior approval by ADHS/DBHS.

VII. Medical Records and Communications

(C-D-17, C-D-21, C-D-23-A-3, AMPM 940-2-a, AMPM 940-3-a)

Contractors must ensure effective and continuous patient care through medical record documentation of each member's health status, changes in health status, health care needs and services provided. [ADHS/DBHS Provider Manual Section 4.2, Behavioral Health Medical Record Standards](#) (Attachment F) establishes *minimum required elements* for member medical records, including processes for the use of digital (electronic) signatures when electronic documents are utilized.

ADHS/DBHS utilizes the ADHS/DBHS Behavioral Health Service Provision Tool and the Medical Record Review Tool (Attachment L) to review Contractor medical records. ADHS/DBHS ensures all Contractors' QM programs comply with the required elements of Provider Manual Section 4.2 (the Behavioral Health Service Provision Tool, and the Medical Record Review Tool) through review of Contractor QM Plans.

ADHS/DBHS conducts quality reviews of Contractor medical records to assess compliance with ADHS/DBHS minimum required elements for Medical Record through *ad hoc* data validation site visits, quarterly record reviews for performance measures, and during the Annual Administrative Review. Identified deficiencies result in technical assistance and CAPs, and are monitored until improvement is sustained.

ADHS/DBHS ensures that each behavioral health recipient is guaranteed the right to request and receive a copy of their medical record; and to request that the record be amended or corrected, per Provider Manual Section 4.2.7-C (Attachment F) and as specified in *45 C.F.R. Part 164*.

To protect the confidentiality of behavioral health recipient medical information and ensure compliance with HIPAA requirements, ADHS/DBHS utilizes Policy and Procedure Manual Section CO 1.4 (Confidentiality), and Provider Manual Section 4.1 (Disclosure of Behavioral Health Information-Attachment F). All ADHS/DBHS Contractors and their sub-contractors must adhere to the requirements pertaining to the release of protected, confidential health information as mandated within these guidance documents.

VIII. Credentialing and Re-Credentialing Processes

(C-D-17, C-D- 23, C-D-23-A-5-a, C-D-23-6, AMPM 910-C, AMPM 950-B, AMPM 950-D, AMPM 950-F-1-b-4, AMPM 960-A)

ADHS/DBHS delegates organizational and provider credentialing to its Contractors (including temporary credentialing, initial credentialing, and re-credentialing). ADHS/DBHS requires Contractors to develop and implement credentialing policies, procedures and protocols that meet AHCCCS and ADHS/DBHS requirements. Contractors must utilize the Contractor Credentialing Committee, Peer Review Committee or similar body to oversee credentialing and re-credentialing decisions. The Contractor's Medical Director or other designated physician is responsible for oversight of the credentialing process. Contractors and subcontractors must utilize participating Arizona Medicaid network providers in making credentialing decisions.

Contractors must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process. Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-alike Center, as well as hospital employed physicians (when appropriate), must be credentialed using the temporary or provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional.

Contractors shall have 14 days from receipt of a complete application within which to render a decision regarding temporary or provisional credentialing. ADHS/DBHS provides oversight, monitoring and technical assistance when needed. Contractors' credentialing processes and files (a random sample of 30 files for each type of credentialing: temporary, initial, and re-credentialing) are reviewed during the ADHS/DBHS Annual Administrative Review to ensure that providers are appropriately credentialed.

Credentialing processes must include records of onsite inspections of non-licensed providers to ensure compliance with credentialing requirements. The credentialing process must include a mechanism for providers to appeal credentialing decisions.

Contractors must appropriately re-credential their subcontracted providers every three years.

ADHS/DBHS mandates that Contractors utilize the ADHS/DBHS Credentialing and Re-credentialing Tools (Attachment E) for all credentialing activities for all provider types. Provider Manual Policy Section 3.20, Credentialing and Recredentialing (Attachment F) includes the Contractors' requirements for this function.

IX. Tracking and Trending of Member and Provider Issues

(C-D-17, C-D-23 A-3, C-d-23-6-a, b and d, AMPM 960 B-1-2-a thru d, AMPM 960 B-3 thru 7, BBA 438.420 (a) (b) (3))

Non-Quality of Care (Complaints, Appeals and Grievances)

ADHS/DBHS defines the issues captured in the non-quality of care process in the following ADHS/DBHS Policies, Procedures and Provider Manual sections:

- Policy GA 3.6 Complaint Resolution
- Provider Manual Section 5.2 Member Complaints
- Provider Manual Section 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
- Policy G.A. 3.3 Title XIX/XXI Notice and Appeal Requirements
- Policy GA 3.5 Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI) (Attachment F) and the ADHS/DBHS BQMO Specifications Manual, Complaint Reporting (Attachment K)

ADHS/DBHS defines a complaint as “*An expression of dissatisfaction with any aspect of care, other than the appeal of actions.*” Complaints may be filed directly with the Contractor and/or with ADHS/DBHS and may originate from behavioral health recipients, family members/guardians, providers, or other stakeholders, including Legislators, AHCCCS, the Governor’s Office and the Center for Disability Law. Complaints filed with ADHS/DBHS are directed back to the Contractor from which the involved behavioral health recipient receives services for action. The Contractors must inform ADHS/DBHS of the outcome of the complaint within timeframes specified by ADHS/DBHS Customer Service.

ADHS/DBHS delegates the tracking, resolution and reporting of complaint data for all TXIX/TXXI adults and children to its Contractors. The Contractors must include in these processes, at a minimum, the investigation and resolution of the complaint, any interventions implemented from the complaint data, and closure of the complaint. Any complaint may be elevated to the Contractor appeal and/or QOC processes as warranted by the complaint investigation findings.

ADHS/DBHS monitors this process through two Contractor reports submitted monthly to ADHS/DBHS OPI. First, complaint logs are submitted indicating the number of persons filing complaints each month, along with summarized information about the complaints. Additionally, Contractors report information about complaints resolved during the month in a separate monthly report in a template based on the AHCCCS Grievance System Reporting Guide. Both reports are described in the ADHS/DBHS BQMO Specifications Manual (Attachment K).

ADHS/DBHS defines an appeal as “*A request for review of an action.*” An “Action” is defined as:

- The denial or limited authorization of a requested service, including type and level of service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or part, of payment for a service
- The failure to provide a service in a timely manner
- The failure of a Contractor to act within the time frames for service as indicated contractually
- For an enrollee residing in a rural area with only one Contractor, the denial of an enrollee’s request to exercise the right to obtain services outside the Contractor’s network

ADHS/DBHS requires timely and complete Notices of Action (NOA) are provided to members or their legal representatives, consistent with AHCCCS requirements, when an action is taken in response to a request for service. The ADHS/DBHS Office of Grievance and Appeals (OGA), in conjunction with AHCCCS monitoring activities, conducts Notice of Action (NOA) audits of all ADHS/DBHS Contractors to measure compliance with AHCCCS and ADHS/DBHS NOA requirements. In addition to monitoring the procedural requirements and legal sufficiency of the NOAs, ADHS/DBHS reviews the NOAs for compliance with clinical decision-making expectations of AHCCCS and ADHS/DBHS, and provides follow-up to Contractors when clinical concerns are identified.

Appeals are initiated at the Contractor level, and if not resolved there, may be further appealed to ADHS/DBHS or AHCCCS, depending upon the appeal process used by the member (Title XIX/XXI Appeal Process or SMI Appeal Process).

ADHS/DBHS defines a grievance as: “*A complaint that is filed by a person with a Serious Mental Illness (SMI) or other concerned person regarding a violation of the person with SMI’s rights or a condition requiring an investigation.*” Like appeals, grievances are generally first filed with Contractors, and to the extent the client disagrees with the outcome, may be appealed further to ADHS/DBHS. ADHS/DBHS directly investigates the most serious grievances, client abuse and death cases.

ADHS/DBHS conducts quarterly audits of the Contractors to ensure adherence to procedural requirements, requiring corrections of any Contractor that is found non-compliant with the established standards. The quarterly review findings are used for scoring of the Contractors in the ADHS/DBHS Annual Administrative Review.

The ADHS/DBHS receives quarterly grievance system reports from Contractors. The reports summarize data and Contractor analysis, trending and follow-up action related to data on appeals, grievances, claims disputes and repetitive filings by individuals. The ADHS/DBHS Office of Grievance and Appeals reports pertinent findings in statewide grievance and appeals data to the ADHS/DBHS QM Committee quarterly. Complaint, grievance and appeals data are synthesized with data from other relevant data sources to

identify problematic system issues requiring corrective interventions. Corrective interventions can include CAPs, sanctions, and other contractual remedies.

ADHS/DBHS requires that Contractors ensure that all staff with direct contact with behavioral health members are trained to assist the member in the filing of all complaint, appeal, and grievance paperwork and the identification of means to resolve issues outside of the Contractor process, such as ADHS/DBHS Customer Service, ADHS/DBHS Office of Human Rights, local Human Rights Committees, and other available advocacy and support options.

Quality of Care (C-D-23, AMPM 910 C-5-e; 960 C, D)

ADHS/DBHS and its Contractors conduct QOC reviews of member care. The ADHS/DBHS Office of Performance Improvement (OPI) receives QOC issues from a variety of sources. If submissions contain immediate healthcare concerns, OPI contacts the DBHS Office of Customer Service. The general QOC process is as follows:

1. ADHS/DBHS Contractors and their providers are required to submit all Incident, Accident and Death (IAD) reports to ADHS/DBHS-BQMO/Office of Performance Improvement (OPI) for review and investigations.
2. QOCs are also submitted to BQMO/OPI from other internal and external agencies: Office of Behavioral Health Licensing (OBHL), Office of Consumer Rights, ADHS Director's Office, DES/DDD, Human Rights Agencies, Stakeholders and the Governor's Office. (C-D-23, AMPM 920 C-1-f, AMPM 960 C-1-c)
3. IADs and QOC concerns are entered by QOC Admin Support into a QOC database
4. IADs are reviewed by OPI-QOC staff in a weekly QOC Team meeting; Inter-Rater Reliability (IRR) checks are done on a weekly basis and potential QOC concerns are identified through consensus.
5. QOC staff initiate a QOC investigation process; reports of abuse, neglect and deaths are all considered potential QOC concerns and treated as such. If additional allegations are identified during the investigation process, they are added to the original QOC.
6. ADHS/DBHS assigns each QOC a level of severity and categorizes the QOC as per AHCCCS Contract, AMPM manual and ADHS/DBHS-BQMO Quality of Care Desktop Protocol (Attachment F).
7. A QOC opening letter is sent to respective Contractors for each potential QOC concern asking for investigation.
8. ADHS/DBHS notifies AHCCCS about the investigation's status through a weekly report, and closing timelines are identified for each potential QOC.
9. At the end of the process a closing letter is sent to AHCCCS.

Contractors must maintain a confidential file that documents their QOC review processes and make the data available to ADHS/DBHS OPI for review, as requested. The ADHS/DBHS QOC process operates under the protections provided by the A.R.S. and federal protections as follows:

[42 U.S.C. 1320c-9](#); [42 U.S.C. 11101 et seq.](#); [42 CFR 51.41 \(c\) \(4\)](#); [A.R.S §36-441-A.R.S. §36-445](#); [A.R.S. §36-2401](#); [A.R.S. §36-2402](#); [A.R.S. §36-2403](#); [A.R.S. §36-2404](#); [A.R.S. §36-2917](#); [A.R.S. § 36-3407](#); [A.R.S. §41-1092\(3\)](#); [A.R.S. §8-542 AHCCCS Medical Policy Manual \(AMPM\) 910\(A\) \(4\)](#); and [AHCCCS Medical Policy Manual, Chapter 900, Sections 910 & 960](#).

The ADHS/DBHS OPI is staffed with individuals who have the necessary clinical and administrative knowledge and skills to facilitate the investigation, evaluation, analysis, resolution, closure and trending of QOC issues (see BQMO Staff Job Descriptions section) (C-D-17, C-D-23-6, AMPM 960 C-1-a-b).

The ADHS/DBHS OPI is responsible for ensuring that each Contractor conducts a complete, timely and accurate resolution of the issues raised in the QOC. ADHS/DBHS reviews the Contractor's investigation, including whether the concern was substantiated, unsubstantiated or unable to be substantiated; and the severity of the QOC based on the substantiation. The ADHS/DBHS QOC process and Quality of Care Desktop Protocol are delineated in Attachment F.

Depending on the outcome of the investigation, ADHS/DBHS may refer QOC cases to the ADHS/DBHS Peer Review Committee as warranted by the QOC concern investigation (AMPM 960 C-6).

ADHS/DBHS requires and documents annual staff training on the QOC policy for all ADHS/DBHS employees having contact with members or providers (Attachment H), and the DBHS Workforce Development Unit includes Quality of Care training as part of the DBHS New Employee Orientation Training Requirements. The training assists staff in the identification and referral of potential quality of care concerns. FY 2011 QOC Training for all DBHS staff was completed on October 31st 2011 (Attachment G). In order to complete the training, staff was required to take a test with a passing score of seven (7) out of 10. A total of 56 staff participated and completed QOC training; participants were from-Customer Service, Grievance and Appeals, Cultural Competency, the Advocacy Group, CSOC, BQMO, Prevention, Grant Services and Compliance.

ADHS/DBHS oversees the QOC review process. First, it maintains Policy QM 2.7 Quality of Care Concerns (Attachment F) to guide ADHS/DBHS and Contractor QOC activities. Additionally ADHS/DBHS keeps a confidential member record that includes letters to Contractors, e-mails, findings, CAPs, research, documentation, and records reviewed by QOC designees from the ADHS/DBHS OPI.

ADHS/DBHS reports to AHCCCS weekly the number of QOCs identified for Title XIX and XXI members, and quarterly aggregates and reports the outcomes of these investigations (AMPM 920 – C-1-c and C-1-c-(1)-(6)). ADHS/DBHS also tracks, trends and aggregates QOC data on a Contractor level and presents the information to the ADHS/DBHS QM Committee quarterly (C-D-23-A-6-e, AMPM 920 C-2).

ADHS/DBHS monitors Contractor compliance with QOC requirements on a case-by-case basis as well as through the Annual Administrative Review. The Administrative Review tool specifically measures Contractors' compliance in developing CAPs to

reduce and/or eliminate the likelihood of the issue reoccurring, incorporation of successful interventions into the QM program based on the QOC review, assignment of new interventions as appropriate, and the maintenance of the process for resolving the concern from both a systems and a member perspective.

ADHS/DBHS Contractors are required to develop CAPs for problems identified through the QOC concern review process. The CAPs must promote quality and improved care for members receiving services in the behavioral health system. CAPs must address the following:

- Specified types of problems requiring corrective action
- Person or body responsible for making the final determination regarding quality issues
- Types of member/provider actions to be taken to include at a minimum:
 - Education/training/technical assistance
 - Follow up monitoring and evaluation of improvement
 - Changes in processes, structures, and forms
 - Informal counseling, termination of affiliation with provider, and/or appropriate referrals to regulatory agencies, including CPS, APS, and AHCCCS.
- Documentation of assessment of the effectiveness of actions taken
- Method for internal dissemination of findings and resulting work plans to appropriate staff and/or network providers
- Method for dissemination of pertinent information to AHCCCS and/or regulatory boards and agencies (Arizona Department of Health Services, Arizona Medical Board, Arizona State Board of Nursing, etc)

X. Performance Measures

(AMPM 970-B-1-b-(1)-(5)-(7), AMPM 970-B-1-(1)-(7), 7BBA 438.240 (a)(1), 438.240 (b)(1) and (d)(1), 438.240 (c)(I)(ii) and (2)); (C-D-23-A-9, C-D- B-I, AMPM 970 B-d-1, BBA 438.240 (e)(I)(i), BBA 438.240 (a) and (b), BBA 438.240 (c) (1, 2 and 3))

ADHS/DBHS follows the Plan, Do, Study, Act (PDSA) Quality Improvement cycle to evaluate data, assess performance, test interventions and refine activities as necessary. Through its contracts, ADHS/DBHS mandates the use of the PDSA model in every Contractor's QM activities. ADHS/DBHS and its Contractors participate in the continuous assessment and evaluation of system performance.

ADHS/DBHS has included AHCCCS-established minimum performance standard (MPS) and goals within its RBHA contracts and the ADHS/DBHS BQMO Specifications Manual (Attachment K). The current MPS and Goals are presented in the table on the following page.

ADHS/DBHS monitors each Contractor's performance on these measures quarterly. ADHS/DBHS and its Contractors incorporate monitoring of performance measures into provider monitoring processes and take actions, as necessary, to improve performance. The performance measures are reported separately for the TXIX/XXI Adult and Child populations.

Performance is also separately measured for members enrolled with the Arizona Department of Economic Security's Division of Developmental Disabilities (DES/DDD). Performance measure results are reviewed by the ADHS/DBHS QM Committee before submission to DES/DDD and AHCCCS. After approval, results are shared with the public and stakeholders through internal and external committees, such as the RBHA QM Coordinators Committee and DBHS Contractor Compliance Committees, and by publishing aggregate statewide performance measure reports on the ADHS/DBHS website and for analysis in the DBHS Outcomes Framework.

Performance Measure	Minimum Performance Standard	Goal
Access to Care	90%	95%
Behavioral Health Service Plan	85%	95%
Behavioral health Service Provision	85%	95%
Coordination of Care – Communication	85%	95%
Follow Up after Hospitalization for Mental Illness within 7 Days	70%	90%
Follow Up after Hospitalization for Mental Illness within 30 Days	80%	90%
Treatment of Depression	TBD	90%

ADHS/DBHS requires that each Contractor meets the established MPS for each measure per 42 CFR 438.240(b) (1), (2), and (d) (1). Additionally ADHS/DBHS requires continually improved performance measure outcomes from year to year as defined by the AHCCCS Medical Policy Manual (AMPM) Chapter 900. Statistically significant drops in statewide or an individual Contractor's performance level for any measure result in increased technical assistance, development of CAPs or sanction. ADHS/DBHS uses the following definitions for its performance measures:

1. *Access to Care:* The percent of AHCCCS members referred for or requesting behavioral health services for which the first service was provided within 23 days of the initial assessment.
2. *Behavioral Health Service Plan:* The percent of AHCCCS members with current service plans that incorporate the needs and service recommendations identified in their assessments.
3. *Behavioral Health Service Provision:* The percent of AHCCCS members who received the services that were recommended in their service plans.
4. *Coordination of Care (Communication):* The percent of AHCCCS members for whom behavioral health service providers communicate behavioral health clinical and contact information with the member's Primary Care Physician (PCP) and/or Health Plan (C-D-23, AMPM 910 A-1-p).

AHCCCS tracks the following measures:

5. *Follow up after Hospitalization for Mental Illness:* The percent of discharges for members age 6 years and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit or partial hospitalization

with a behavioral health practitioner, based on Healthcare Effectiveness Data and Information Set (HEDIS) criteria. Two rates will be reported: members who received follow up within 30 days of discharge and members who received follow up within 7 days of discharge.

6. *Treatment of Depression:* The percent of continuously enrolled AHCCCS members diagnosed with major depressive disorder of mild subtype who received an antidepressant medication or psychotherapy during the measurement period.

Performance Reporting for Special Populations

ADHS/DBHS identifies behavioral health recipients who are also enrolled in services with the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) as meeting the definition of special populations. The following ADHS/DBHS performance measures are monitored and reported for DES/DDD behavioral health recipients:

- Access to Care
- Coordination of Care – Communication
- Behavioral Health Service Plan
- Behavioral Health Service Provision

ADHS/DBHS reports performance for this special population separately in the FY11 Annual Performance Improvement Reports, in addition to sending quarterly reports on recipient utilization, Access to Care and Coordination of Care to DES/DDD.

XI. Performance Improvement Projects

(C-D-23-A-9, C-D-23-B-II, BBA 438.240(e)(1) and 438.240(d)(2) and AMPM 980-B-2)

ADHS/DBHS utilizes data derived from quality management activities in the development of PIPs per the AMPM Chapter 900 and the Provider Manual Section 8.4 Performance Improvement Projects (Attachment F). ADHS/DBHS may conduct PIPs for both clinical and non-clinical areas. The PIPs utilize structured methodologies as approved by AHCCCS for targeted improvement activities. Project topics are determined through data collection and analysis to identify a systemic improvement need.

Data reviewed includes, at a minimum, complaints, grievances, QOCs, performance measures and service utilization data. Projects are considered complete after improvement has been achieved and sustained for a year.

ADHS/DBHS utilizes PIP data in the creation and dissemination of practice protocols, policy development, and quality improvement activities. Contractors are required to participate in any and all activities, including interim monitoring, related to the completion of the following PIP:

Improving Coordination of Care for Acute-Care Members Receiving Behavioral Health Services

The Coordination of Care PIP studies *whether improved coordination between AHCCCS Acute Care medical providers and behavioral health medical providers, including the targeted exchange of opiate and benzodiazepine prescribing data, reduce morbidity and/or mortality among AHCCCS members served through both systems.*

This PIP is co-owned by the ADHS/DBHS and AHCCCS, conceptualized by the ADHS/DBHS former Chief Medical Officer, Dr. Wilson, and implemented by AHCCCS with the help of its Health Plans.

The PIP was implemented in FY 2009 by AHCCCS; first re-measurement was scheduled for AHCCCS Contract Year 2010-2011. ADHS/DBHS-BQMO/OPI is committed to working with AHCCCS to assist with this PIP.

AHCCCS and ADHS/DBHS are co hosting meetings between AHCCCS Health Plans and ADHS/DBHS RBHAs for effective coordination and data sharing for improved performance.

As per the AHCCCS letter to ADHS/DBHS BQMO dated November 15, 2011, the ADHS/DBHS Self-Selected PIP requirement for CYE 2012 has been waived.

XII. Reporting Requirements

ADHS/DBHS reports all AHCCCS performance data per the AHCCCS/ADHS/DBHS contract deliverable schedule as defined by Contract#YH8-0002, Amendment 41 (July 1, 2011), "Attachment C: Periodic Reporting Requirements," and "Summary of Due Dates." ADHS/DBHS requires all Contractors to report performance measures and other QM data at least quarterly.

ADHS/DBHS QM Reporting

- Annual QM Plan, Work Plan and Evaluation
- Annual Consumer Survey
- Annual Performance Improvement Report (Child and Adult)
- Monthly Grievance System Report (Appeals and Claims Disputes)
- Performance Improvement Project Proposals and Interim Reports
- QM Quarterly Report (QOC Report)
- Weekly QOC Report to AHCCCS

ADHS/DBHS Contractor QM Reporting

- Annual Contractor QM Plan, Work Plan and Evaluation
- Quarterly Performance Improvement Report
 - Data included: Complaints, Performance Measures, CAPs, other proxy data such as QOCs
- Monthly Complaint Logs
- Monthly Complaint Resolution Summary (part of Monthly Enrollee Grievance Summary Report)
- Monthly QOC Reports
- Annual Consumer Survey Report

ADHS/DBHS QM also reviews data reports from other ADHS/DBHS functional areas in the ADHS/DBHS QM Committee. The following functional area reports are data feeds for ADHS/DBHS QM:

- Office of Grievance and Appeals Reports
- Adult and Child System of Care Reports
- ADHS/DBHS Quality Management Administrative Review CAP Status Reports
- Office of Individual and Family Affairs Reports
- Other data as identified

ADHS/DBHS ensures all deliverables are submitted to AHCCCS in a timely manner and are complete and error free. ADHS/DBHS Contractors must submit timely, logical and error free reports to ADHS/DBHS for the compilation of statewide reports to AHCCCS. ADHS/DBHS QM reports are reviewed by the ADHS/DBHS Leadership Team for approval prior to submission to AHCCCS.

XIII. List of Attachments

- A – FY2012 Quality Management Work Plan
- B – 2011 Quality Management Work Plan Evaluation
- C – 2011 Quality Management Program Evaluation Summary
- D – Peer Review Policy, Desktop Protocol, and Process Diagram
- E– Credentialing Tools
- F – QM Policies and Procedures
- G – ADHS/DBHS In-House QOC Training Materials
- H– 2012 Plan and Work Plan – QM Committee Approval by CMO
- I– 2012 Plan and Work Plan Approval – ADHS/DBHS Leadership Team
- J – 2012 QM Plan Checklist
- K – ADHS/DBHS 2012 BQMO Specifications Manual (Revised July, 2011 and submitted to AHCCCS 10/1/2011)
- L – Service Provision Tools